JS 44
(Rev. 12/96)

CIVIL COVER SHEET

The JS-44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. (SEE INSTRUCTIONS ON THE REVERSE OF THE FORM.)

I. (a) PLAINTIFFS/Petitioner
PACIFICARE HEALTH INSURANCE COMPANY OF MICRONESIA, INC. dba PACIFICARE ASIA PACIFIC

DEFENDANTS/Respondent
GOVERNMENT OF GUAM

(b) COUNTY OF RESIDENCE OF FIRST LISTED PLAINTIFF _____
(EXCEPT IN U.S. PLAINTIFF CASES)

COUNTY OF RESIDENCE OF FIRST LISTED DEFENDANT _____
(IN U.S. PLAINTIFF CASES ONLY)
NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

(c) ATTORNEYS (FIRM NAME, ADDRESS, AND TELEPHONE NUMBER)
MAIR, MAIR, SPADE & THOMPSON
238 A.F.C. Flores Street
Suite 801 Pacific News Building
Hagatna, Guam 96910 (Tel: 472-2089)

ATTORNEYS (IF KNOWN)
OFFICE OF THE ATTORNEY GENERAL
GOVERNMENT OF GUAM
Suite 2-200E Judicial Ctr. Bldg.
Hagatna, Guam 96910

II. BASIS OF JURISDICTION (PLACE AN "X" IN ONE BOX ONLY)

- ☐ 1 U.S. Government Plaintiff
- ☒ 3 Federal Question (U.S. Government Not a Party)
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity (Indicate Citizenship of Parties in Item III)

III. CITIZENSHIP OF PRINCIPAL PARTIES (PLACE AN "X" IN ONE BOX FOR PLAINTIFF AND ONE BOX FOR DEFENDANT)
(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. ORIGIN (PLACE AN "X" IN ONE BOX ONLY)

- ☒ 1 Original Proceeding
- ☐ 2 Removed from State Court
- ☐ 3 Remanded from Appellate Court
- ☐ 4 Reinstated or Reopened
- ☐ 5 Transferred from another district (specify)
- ☐ 6 Multidistrict Litigation
- ☐ 7 Appeal to District Judge from Magistrate Judgment

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VI. CAUSE OF ACTION (CITE THE U.S. CIVIL STATUTE UNDER WHICH YOU ARE FILING AND WRITE BRIEF STATEMENT OF CAUSE. DO NOT CITE JURISDICTIONAL STATUTES UNLESS DIVERSITY.)

9 U.S.C. §5 - Petition to appoint arbitrator

VII. REQUESTED IN COMPLAINT: ☐ CHECK IF THIS IS A CLASS ACTION UNDER F.R.C.P. 23

DEMAND $ $688,315.00

CHECK YES only if demanded in complaint:
JURY DEMAND: ☐ YES ☒ NO

VIII. RELATED CASE(S) IF ANY (See instructions): JUDGE _____ DOCKET NUMBER _____

DATE
June 18, 2004

SIGNATURE OF ATTORNEY OF RECORD RANDALL TODD THOMPSON

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

RECEIVED
JUN 21 2004
DISTRICT COURT OF GUAM
HAGATNA, GUAM

ORIGINAL

MAIR, MAIR, SPADE & THOMPSON
A Professional Corporation
Attorneys at Law
238 A.F.C. Flores Street
Suite 801, Pacific News Building
Hagåtña, Guam 96910
Telephone: (671) 472-2089/2090

Attorneys for Petitioner PacifiCare Health Insurance
Company of Micronesia, Inc. dba PacifiCare Asia Pacific

IN THE DISTRICT COURT OF GUAM

TERRITORY OF GUAM

IN THE MATTER OF THE ARBITRATION BETWEEN PACIFICARE HEALTH INSURANCE COMPANY OF MICRONESIA, INC. dba PACIFICARE ASIA PACIFIC, Petitioner, and GOVERNMENT OF GUAM, Respondent.	CIVIL CASE NO. 04-00030 **PETITION FOR APPOINTMENT OF THIRD ARBITRATOR BY COURT [9 U.S.C. § 5]**

Petitioner, PACIFICARE HEALTH INSURANCE COMPANY OF MICRONESIA, INC., dba PACIFICARE ASIA PACIFIC ("PacifiCare"), alleges as follows:

1. Petitioner PacifiCare, now is, and at all times mentioned was, a corporation duly organized and existing under the laws of the territory of Guam, with its principal place of business in the village of Tamuning, in the same territory.

2. Respondent Government of Guam (the "Government"), now is, and at all times mentioned was, an unincorporated territory of the United States, duly organized and existing under the laws of the United States, with its principal place of business in the village of Hagåtña, in the same territory.

3. The jurisdiction of the Court is invoked under Title 9, United States Code, and particularly Section 5 thereof, and under Title 28, United States Code, Section 1332. The matter in controversy, exclusive of interest and costs, exceeds the sum of $75,000.00.

4. On or about September 25, 2002, Petitioner and Respondent entered into a contract in writing entitled "2003 Government of Guam/PacifiCare Asia Pacific Health Services Agreement" (hereinafter the "Agreement"). The Agreement set forth the terms, rates and benefits by which PacifiCare would provide health insurance to enrolled Government of Guam employees and retirees during the applicable period. A copy of the Agreement is attached hereto as Exhibit A, and made part hereof.

5. The Agreement evidences a transaction involving commerce as is shown by the following facts:

a. The Agreement was executed, performed in and subject to the laws of the territory of Guam; and commerce within Guam is subject to the Federal Arbitration Act;

b. The subject matter of the contract is the provision of health insurance and health services to government employees within and without the territory of Guam.

6. The Agreement contained an arbitration provision which states, in part, as follows:

> Any dispute or controversy between the parties arising under this Agreement shall be submitted to binding arbitration. Arbitration is initiated and required by giving written notice specifying the issues to be arbitrated.

7. A dispute which comes within the terms of the Agreement to arbitrate has arisen under the Agreement and has been submitted to arbitration. The dispute was set forth in the May 19, 2004 Notice of Impasse and Demand for Arbitration, a true and correct copy of which is attached as Exhibit B and made a part hereof.

8. In brief, the dispute concerns PacifiCare's sustained losses of approximately $688,315.00 as a direct result of actions taken by the Government of Guam which were in breach of the Agreement and by which the Government was unjustly enriched (irrespective of whether the Government's actions constitute a breach of contract). PacifiCare's loss and the Government's unjust enrichment resulted from a September 19, 2003 restraining order handed down by the Honorable Joaquin V.E. Manibusan, Jr., then judge of the Superior Court of Guam, requiring PacifiCare to continue providing insurance coverage to Government of Guam subscribers beyond September 30, 2003, and until further notice of the court. Based upon this bench ruling, PacifiCare was obligated to continue furnishing services and benefits beyond the Agreement's September 30, 2003 deadline, despite the fact that new and higher rates were implemented subsequent to that date. The Government of

Guam only compensated PacifiCare at the outdated and expired rates, leaving PacifiCare unable to recover its health care costs and retention for the applicable period. PacifiCare suffered losses due to the difference between the expired rates paid to PacifiCare and the rates it should have been paid by the Government based upon actuarial rates.

9. The Arbitration Agreement describes the method for the appointment of three arbitrators, with one arbitrator to be appointed by each party, and with the two arbitrators thus appointed in turn to appoint a third arbitrator. In this instance, each party has duly nominated and appointed its own arbitrator. However, the two arbitrators have, as of this date, failed to agree upon and appoint a neutral, third arbitrator; and the time within which the arbitrator should have been appointed has expired.

10. Because of the failure of the arbitrators to select a neutral, third arbitrator, Petitioner seeks relief, pursuant to Title 9, United States Code, Section 5, which authorizes this Court to designate and appoint an arbitrator to fill a vacancy where there has been a lapse in filling such vacancy by the parties or the arbitrators, by requesting the Court to order the appointment of a neutral, third arbitrator to act with the same force and effect as if specifically appointed by the two-party nominated arbitrators, and that Petitioner be granted such other and further relief as may be proper.

Dated this 18th day of June, 2004.

MAIR, MAIR, SPADE & THOMPSON
A Professional Corporation
Attorneys for Petitioner PacifiCare Health Insurance Company of Micronesia, Inc. dba PacifiCare Asia Pacific

By: _____
RANDALL TODD THOMPSON

P04271.rtt

VERIFICATION

I, DONALD FETHERMAN, being first duly sworn, do state that I am the authorized representative for Petitioner PACIFICARE HEALTH INSURANCE COMPANY OF MICRONESIA, INC. DBA PACIFICARE ASIA PACIFIC, that I have read the allegations herein and the same is true of my own knowledge, except as to those matters which are stated on information and belief, and as to those matters, I believe them to be true.

Dated: 6/16/04

DONALD FETHERMAN, Vice President

TAMUNING, GUAM) ss:

SUBSCRIBED AND SWORN to before me this 18th day of June, 2004, by DONALD FETHERMAN.

MARTHA Q. IGNACIO
NOTARY PUBLIC
In and For Guam, U.S.A.
My Commission Expires: Sept. 21, 2006
238 A.F.C. Flores Street, Suite. 801
Pacific News Building, Hagatna, Guam 96910

P04271.rtt

2003

GOVERNMENT OF GUAM/PACIFICARE ASIA PACIFIC

GROUP HEALTH INSURANCE AGREEMENT

HEALTH SERVICES AGREEMENT

0168

EXHIBIT A

PCAP 0001

GOVERNMENT OF GUAM/PACIFICARE ASIA PACIFIC HEALTH SERVICES AGREEMENT

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GOVERNMENT OF GUAM/PACIFICARE ASIA PACIFIC HEALTH SERVICES AGREEMENT

This Agreement and Attachment I Group Membership Agreement, Attachment II Grievance Procedure, Attachment III Arbitration, Attachment IV Quality Improvement, Attachment V Utilization, I-A Medical Rates & Benefits and I-B Dental Rates & Benefits are executed by and between the Government of Guam, Hagatna, Guam (hereinafter "GovGuam") and PacifiCare Health Insurance Company of Micronesia, Inc., doing business as PacifiCare Asia Pacific, 155 E.T. Calvo Memorial Park, Tamuning, Guam 96911. (hereinafter "PacifiCare") and its successors in interest.

WHEREAS, this document constitutes the integration of that Agreement between GovGuam and PacifiCare entered into on June 12, 1973 for the provision of health care services for a fixed monthly Premium and all amendments subsequent thereto as of the date this Agreement is executed; and

WHEREAS, PacifiCare is an insurance company licensed to do business on Guam; and

WHEREAS, GovGuam has selected PacifiCare as a Health Insuring Organization to provide group health insurance plan benefits for active and retired employees and survivors of retired employees who receive an annuity benefit from GovGuam; and

WHEREAS, PacifiCare is professionally and financially qualified and able to provide group health insurance plan benefits provided herein; and

WHEREAS, the parties are desirous and willing to enter into this Agreement defining their mutual rights and obligations, one to the other;

NOW THEREFORE, in consideration of the mutual promises herein contained and in further consideration of the payment by GovGuam to PacifiCare, GovGuam and PacifiCare hereby agree as follows:

I. DEFINITIONS

1.1. Contractor means PacifiCare.

1.2. Eligible Individual means an eligible GovGuam employee, retired employee, survivor of a retired employee receiving annuity benefits or an Eligible Dependent thereof, who is eligible to enroll in the Plan in accordance with the procedures established herein.

1.3. Eligible Dependent: Eligible Dependent shall include only the Subscriber's spouse or common-law spouse (as defined herein) unless legally separated and the Subscriber's unmarried children from birth to the child's nineteenth birthday, who primarily depend upon the Subscriber for support per Internal Revenue Service definitions. Subject to Public Law No. 22-101, Section 95-101, the word "children" shall only include the Subscriber's natural children, legally adopted children, children placed for adoption with the Subscriber and those children under the Subscriber's legal guardianship living with the Subscriber. Subscribers claiming legal guardianship shall be required to provide both of the following: (I) a court order granting guardianship to the Subscriber and (ii) the Subscriber's prior year's tax return identifying the child as a dependent. If the child is not on the Subscriber's prior year tax return, a signed affidavit stating that such child will be so identified on the current year's tax return will be accepted. On request, the Subscriber must provide a copy of such tax return, within thirty-one (31) days of filing, to PacifiCare. If the child is not therein identified as a dependent, the child will be retrospectively terminated effective October 1 of the current plan year, and the Subscriber will be liable to reimburse PacifiCare for the cost of all services which had been covered for the child. Furthermore, children covered under legal guardianship can only be enrolled during an open enrollment period. Any unmarried child who continues to be dependent upon the Subscriber and is a full time student shall continue as an Eligible Dependent up to but not including his or her twenty-third birthday. Notwithstanding the nineteen-year-old limitation, coverage shall be continued where dependent children can be certified as incapable of

obtaining self-sustained employment by reason of mental retardation or physical handicap and are primarily dependent upon Subscriber for support and maintenance, provided proof of such incapacity and dependency is furnished to PacifiCare within thirty-one (31) days of request. Such certification will consist of a statement by a qualified physician.

1.4. GovGuam means the Government of Guam including all branches thereof and all public corporations and autonomous agencies thereof.

1.5. Health Insuring Organization means an organization legally operating within Guam that pays for the cost of medical services provided to and obtained by its beneficiaries in exchange for a premium and which assumes an Underwriting Risk. A Health Insuring Organization means an organization legally operating within Guam that provides, either directly or through arrangements with others, health services to individuals enrolled with such organization on a prepayment basis and which assumes an Underwriting Risk. A Health Insuring Organization's meaning is inclusive of a Health Maintenance Organization.

1.6. Member means any Subscriber or Eligible Dependent who is enrolled in the Plan.

1.7. Premium means the amount paid by GovGuam or a Subscriber to PacifiCare for each Member enrolled under the Agreement for the provision of medical and/or dental care.

1.8. Plan means the specific medical or dental benefits purchased from the Contractor for Members by GovGuam.

1.9. Underwriting Risk means a significant risk of loss assumed by a Health Insuring Organization.

1.10. Subscriber shall mean any eligible GovGuam employee, retiree or survivor who is enrolled in the Plan.

II. TERM AND TERMINATION

2.1 Term. This contract, in its original form, became effective August 1, 1973. It shall renew automatically for one year each October 1st unless terminated for major default in availability or quality of services, given by

written notice from the Government of Guam to PacifiCare not less than ninety (90) calendar days before the renewal date, or unless modified by mutual agreement. Time is of the essence to the covenants of this paragraph.

2.2 Suspension of Performance by PacifiCare. Should any Department, Agency, or Authority of GovGuam fail to pay any Premium when due under this Agreement, PacifiCare shall have the right to suspend performance or terminate membership under this Agreement with respect to Members whose Premium have not been paid by said Department, Agency or Authority. PacifiCare may not invoke its right to suspend performance or terminate Membership under this Agreement prior to 15 working days following written notice from PacifiCare to the Department of Administration and to the relevant Department, Agency, or Authority of GovGuam and to the Member. Such notice shall include complete information regarding the alleged late Premium including the amount, documentation showing how such amount was calculated, and PacifiCare's efforts to collect such amount. Subject to Section 4.5 of this Health Services Agreement, any service rendered after the date performance was suspended or membership terminated will be charged to the Member on a fee-for-service basis.

2.3 Termination for Failure to Appropriate Funds. In the event of non-payment of Premium as herein provided due to unavailability of appropriations by the Legislature, this contract shall terminate.

III. RATES, PAYMENTS AND BENEFITS

3.1 Rates. PacifiCare guarantees the rates set forth in Attachments I-A and I-B.

3.2 Schedule of Payment. The Premium due under this Agreement shall be paid by GovGuam to PacifiCare within five (5) calendar days after the close of each GovGuam payroll period. Each such Premium payment shall be for the preceding pay period. The initial Premium payment shall include and cover any Member whose enrollment application is effective October 1. Full Premium payment constitutes a discharge of

GovGuam's responsibility for the cost of health care services provided pursuant to this Agreement.

3.3 Benefits. GovGuam authorizes and accepts PacifiCare to provide, and PacifiCare hereby agrees to provide health insurance benefits for Members as herein described, who enroll in PacifiCare in accordance with this Agreement. The parties agree that Attachments I-A and I-B entitled Medical/Dental Rates and Benefits and Attachment I entitled PacifiCare Group Membership Agreement contain the benefits, rates, terms, conditions, limitations and exclusions pertaining to the provision of medical and dental services under this Agreement. The parties further agree that Attachment II entitled PacifiCare Appeals and Grievance Procedure contains the grievance procedure provisions under this Agreement. The parties further agree that Attachment III entitled Arbitration Procedure contains the arbitration procedure provisions under this Agreement. The parties further agree Attachment IV entitled Quality Improvement contains the quality assurance procedure provisions under this Agreement. The parties further agree that Attachment V entitled Utilization contains the utilization procedure provisions under this Agreement. The foregoing attachments are hereby incorporated and made a part of this Agreement.

IV. MARKETING AND ENROLLMENT

4.1 Open Enrollment. The parties to this Agreement shall annually establish one open enrollment period. During such period, GovGuam agrees to provide PacifiCare with the assistance and cooperation as described in this Agreement. Except as otherwise provided herein, the open enrollment period established by this Agreement is the only time during which current eligible GovGuam employees, retired employees and survivors of retired employees shall be allowed to enroll in the PacifiCare Plan or to disenroll from this Plan as of the October 1 first following the open enrollment period. If an individual is dissatisfied with the application of this section, the individual may apply for a waiver of the provisions of this paragraph through the grievance procedure.

4.2 Exceptions to Open Enrollment. Any individual who becomes a GovGuam employee, or for any other reason becomes eligible for this Plan, after the close of the open enrollment period, shall have thirty-one (31) days after the date on which he/she became a GovGuam employee, or otherwise eligible, to enroll in this Plan.

4.3 Should GovGuam deem it necessary to hold a special open enrollment due to termination of a contract with a GovGuam Health Insuring Organization, PacifiCare will participate in that open enrollment unless otherwise mutually agreed to or unless PacifiCare is the terminating Health Insuring Organization.

4.4 Departmental Designees. GovGuam shall designate one person within each department to be responsible for the handling of health insurance problems, enrollment, cancellations and other duties specified herein that arise within their particular department. These people, as part of their job, shall be required to attend meetings for the purpose of reviewing PacifiCare administrative procedures and problem solving. PacifiCare shall be entitled to visit or call daily the appropriate Guam Personnel Departments to receive the names and social security numbers of those GovGuam employees most recently terminated. GovGuam shall cooperate in providing PacifiCare with such names and social security numbers.

4.5 Notice by GovGuam to PacifiCare Regarding Changes in a Subscriber's Status. GovGuam shall notify PacifiCare in writing of terminations, resignations, department transfers, or other changes in a Subscriber's employment status, so that coverage can be terminated at the appropriate time. GovGuam, including autonomous departments, shall make available to PacifiCare a computer produced listing of each Subscriber receiving a payroll deduction for PacifiCare coverage no later than five (5) working days following each payday. In the event that GovGuam does not provide said list of eligibility within the five (5) working days allowed by this paragraph, PacifiCare shall have the right to charge the individual for any services rendered prior to written verification of eligibility and enrollment by GovGuam. GovGuam shall respond in writing to any PacifiCare written inquiry regarding the coverage status of

any person within ten (10) working days. If any individual who is denied coverage by PacifiCare is subsequently determined to be eligible and covered for the services rendered and GovGuam remits a Premium payment for the individual for the period for which services were rendered, PacifiCare shall cancel all charges to the individual and remit any amounts collected.

4.6 Notice to PacifiCare of Subscriber's Leave of Absence.

4.6.1 Military Leave. PacifiCare shall be notified in writing in advance of any Subscriber's military leave of absence. Coverage will continue for Subscribers, who enter active military service for the shorter of the eighteen (18) months or the duration of the service, and for their enrolled Eligible Dependents, provided Premiums are paid. Even if the Subscriber elects not to continue coverage for himself or herself or any Eligible Dependents during the Subscriber's military service, the individual and all Eligible Dependents will be eligible to immediately re-enroll, without waiting period or evidence of insurability, upon the individual's return to work. PacifiCare will not provide coverage for a Member for any injury or illness determined by the Secretary of Veterans' Affairs to have been incurred or aggravated during military service. The provisions of this paragraph are notwithstanding any other section of this Agreement.

4.6.2 Leave Without Pay. PacifiCare shall be notified in writing before any Subscriber commences leave without pay. If a Subscriber is granted leave without pay, he or she and his or her enrolled Eligible Dependents may remain enrolled in the PacifiCare Plan for a maximum of twelve (12) months, provided the Subscriber prepays quarterly Premiums directly to PacifiCare not less than thirty (30) days prior to the expiration of coverage. It will be the Subscriber's responsibility to provide documentation to PacifiCare indicating approval of his or her leave. Notwithstanding the aforesaid, if the leave is taken pursuant to the Family and Medical

Leave Act of 1993, PacifiCare will fully cooperate in assisting GovGuam in complying with this Act.

4.6.3 Sabbatical Leave. PacifiCare shall be notified in writing before the commencement of any Subscriber going on sabbatical leave. If a Subscriber is granted sabbatical leave without pay, he or she may remain a Subscriber for a maximum of twelve (12) months in the PacifiCare Plan, provided he or she prepays quarterly Premium directly to PacifiCare not less than thirty (30) days prior to the expiration of coverage. It will be the Subscriber's responsibility to provide appropriate documentation to PacifiCare indicating approval of his or her leave.

4.6.4 Disability Leaves. PacifiCare will provide covered services for all pending disability cases if PacifiCare receives written notice of the disability claim. If the claim is allowed, GovGuam will collect and remit all past due Premium to PacifiCare. If the claim is denied, the Subscriber must pay the Premium , through GovGuam, for all missed pay periods. If the Subscriber returns to work with GovGuam, the Subscriber shall be double-deducted (1 extra deduction every pay period) for the full Premium (including GovGuam's share) due PacifiCare for those pay periods while on pending disability leave. If the pending disability claim is denied and the Subscriber does not return to work, GovGuam will have no obligation to collect or remit any past Premium to PacifiCare. GovGuam will collect and remit full Premium for all eligible, disabled Subscribers through the GovGuam Retirement Plan to PacifiCare.

4.6.5 Dependents of Subscribers on Leave. If a Subscriber is eligible to continue coverage while on leave of absence, the Subscriber's enrolled Eligible Dependents are also eligible provided appropriate Premiums are paid.

4.7 Effect of Enrollment. By enrolling in PacifiCare, Members agree to the terms, provisions and conditions of this Agreement and its attachments.

4.8 Marketing. PacifiCare shall print and provide necessary brochures, announcements, instructions, enrollment forms, and certificates for

enrollment and for distribution to GovGuam employees and will be responsible for the education and dissemination of information to GovGuam employees regarding PacifiCare. GovGuam shall give PacifiCare reasonable assistance and cooperation to enable PacifiCare to contact all sources of enrollment, to disseminate all information, to provide access to employees during working hours, to provide all employees' names and addresses, and to instruct GovGuam department heads to give PacifiCare representatives adequate opportunity for personal contact with employees for the purpose of explaining the PacifiCare Plan.

4.9 No Maximum Enrollment. There shall be no restriction or limitation on the percentage of enrollment for the PacifiCare Plan.

4.10 Involuntary Disenrollment. PacifiCare may terminate a Member under this Agreement in any of the following situations:

a. The termination of the Agreement;

b. The non-payment of Premiums on behalf of a Member after the applicable Department, Agency, Authority and Member have been provided written notification of such non-payment at least thirty (30) days in advance of the proposed date of termination;

c. The loss of eligibility as a dependent of the Subscriber. A Subscriber's spouse's coverage shall terminate upon the termination of the marriage to the Subscriber. A Subscriber's Child's coverage shall terminate upon the Child's marriage, attainment of age as specified in Section A.I.3 of this Agreement, or independence from the Subscriber's support. A dependent's coverage shall terminate as of the first day of the pay period following the date he or she no longer meets the eligibility requirements defined in this Agreement, unless otherwise governed by court order. Premiums must be paid until the date of termination.

d. Upon thirty (30) days' notice if:

i. The Member fails to pay copayments or deductible charges required by this Agreement, or refuses to reimburse PacifiCare for the value of any services falsely received under

Section 4 or 5 of the Group Membership Agreement or any other section of this Agreement. In these cases, the Member will be given thirty (30) days notice prior to termination. A Member terminated under the provisions herein shall only be terminated from the specific service Plan (medical or dental) for which Premiums , copayments or deductibles were not paid; or

ii. a Member allows another person to use their identification card to obtain services; or

iii. a Member fails to continuously reside in the PacifiCare Service Area as defined herein; or

iv. a Member fails to notify PacifiCare of a change of address to a location outside of the PacifiCare Service Area; or

v. a Member is involved in two (2) or more instances of disruptive conduct and the PacifiCare Medical Director determines that the Member's conduct is not caused by the Member's medical condition or by prescribed medication.

vi. A Member's refusal to participate in the Medicare program when eligible and offered at no cost to the member via assistance from PacifiCare

e. If a Member is terminated as described above, all rights to benefits cease as of the date of termination.

f. PacifiCare will notify each Member in the event of the termination of this entire Agreement. This notification will consist, at a minimum, of a letter to each household using the last known address in PacifiCare's files. PacifiCare may also publish notice of said termination in the Pacific Daily News or other suitable publication.

g. If PacifiCare terminates this Agreement with an individual Member, PacifiCare will notify the Member via a letter sent to the Member's last known address in PacifiCare's files. Termination of coverage will also be noted in the membership system, which will notify PacifiCare providers of the termination when service is requested. PacifiCare will also send a notice to the Department of

Administration. Such letter will inform the Member of his or her right to appeal the decision in accordance with the Appeal and Grievance Procedure.

4.11 Disenrollment From Dental Plan. A Member in the PacifiCare Dental Plan may only disenroll from this Plan during an open enrollment period to be effective on the first October1 following the open enrollment period. Otherwise, a Member may only disenroll if he or she loses eligibility as defined in the PacifiCare Group Membership Agreement.

4.12 Return to Work Slips. GovGuam shall eliminate the requirement that a GovGuam employee who takes sick leave be required, after the fact, to obtain a physician's signature on a sick slip. In the event of a continued pattern by an employed Subscriber in taking sick time, the Subscriber's supervisor may refer the Subscriber to his or her Primary Care Provider for an appropriate medical examination or treatment.

4.13 If a Member's coverage is terminated because PacifiCare has elected to terminate this Agreement and that Member is confined in an inpatient facility covered under this Agreement on the effective date of such termination, the Member may remain in the PacifiCare Plan until the earliest of the Member's (a) date of discharge, (b) date of benefit exhaustion, or (c) effective date of coverage under the new plan. PacifiCare agrees that no Premium shall be due for this period of extended coverage.

V. RENEGOTIATION OF PRICE AND TERMS

5.1 Schedule of Renegotiations and Open Enrollment. The following will be used in annual rate and benefit negotiations. PacifiCare and GovGuam will make best efforts to adhere to this schedule. Time is of the essence to the covenants in this paragraph.

5.1.1 May 15. Contractor submits new rate and benefit proposals and supporting data. Supporting data shall include:

1. Depreciation Schedule for Contractor's Guam operation;

2. Explanation of how the proposed rate, if any, is determined. This explanation will include utilization information of services rendered to Members through this Plan;
3. Balance Sheet and Profit and Loss Statement for 12-month period ending December 31. If the audited statement is not available, a preliminary statement will be submitted and the audited statement will be submitted as soon as possible thereafter.
4. Projected GovGuam experience for the 12-month period ending December 31.
5. For statements required by Subsection 3 hereof, detail of fixed asset additions, a schedule of bad debts reserve adjustment, and a detailed schedule of bad debts, insurance, and taxes for Contractor's Guam operation shall be provided.
6. Brochures are prepared and transmitted to GovGuam for review.

5.1.2 August 1. Best efforts will be made to agree upon rates with all Health Insuring Organizations.

5.1.3 September 4-28. Open enrollment for next fiscal year if rates for all Health Insuring Organizations have been concluded; otherwise open enrollment will be held when the rates for all Health Insuring Organizations have been concluded.

5.1.4 September 15 - 30. Enrollment cards are tabulated and submitted to that specific Health Insuring Organization in which the applicant intends to enroll.

5.2 Additional Information to be Submitted by PacifiCare. PacifiCare warrants that it shall present with its proposal all materially relevant substantiating information affecting its rate, both experienced and anticipated, in the GovGuam Plan. This presentation shall include such financial information or records that relate to PacifiCare's GovGuam line of business and are required by GovGuam, in accordance with Section 4019.1 of the Government Code as amended and as further described in any regulations implementing said statute. PacifiCare hereby agrees that it will continue to provide the information required by the terms of this Agreement and will further cooperate in providing GovGuam with additional financial, loss ratio and utilization data appropriate. On or before July 1, if at all possible, but in no

event later than October 1, PacifiCare shall provide GovGuam with an audited financial statement prepared by PacifiCare's outside independent auditor, for the fiscal year ended December 31, for the PacifiCare Guam operation. PacifiCare further agrees that it will provide GovGuam with a certified audited statement prepared by independent auditors which will show whether or not the GovGuam portion of PacifiCare's business is fairly and accurately stated.

VI. COVENANTS OF GOVGUAM

6.1 Contracts Shall Not Cause Unfair Competition. GovGuam warrants that it shall not enter into any agreement with any Health Insuring Organization which would result in unfair and destructive competition to PacifiCare or which would discriminate against PacifiCare.

6.2 No Recovery of Losses by Health Insuring Organizations. Any contract between GovGuam and any Health Insuring Organization shall include a provision which states that any Premium shall not include payment for the recovery of any losses incurred for the Underwriting Risk which it has assumed under any prior GovGuam contract.

6.3 Contracts With Other Health Insuring Organizations Permitted. GovGuam may solicit and contract with other individuals, partnerships, associations, or corporations to provide health care coverage for the GovGuam active and retired employees and their dependents and survivors of retired employees who receive annuity benefits. It is the intention of the parties that, in the event GovGuam does contract as aforesaid, such contracts shall have no effect on the continued existence of this Agreement. GovGuam agrees that it will continue full cooperation in making available to all Eligible Individuals PacifiCare coverage irrespective of the existence of any other health care contract.

VII. COVENANTS OF PACIFICARE

7.1 Financial Records. PacifiCare will maintain adequate financial and statistical records as customarily utilized under PacifiCare's accounting

system and under generally accepted accounting principles and shall make such records available to GovGuam for its examination, pursuant to its request. An accounting of financial operations conducted under this Agreement shall also be available upon request.

7.2 Access to PacifiCare. PacifiCare agrees that participation in providing health care benefits under PacifiCare will be open to any qualified medical group on Guam upon the standard PacifiCare terms and conditions and at the sole discretion of PacifiCare.

7.3 Quality Assurance. PacifiCare will establish a plan of quality assurance, which plan will be available to GovGuam for inspection and information.

7.4 Confidentiality of Medical Records. All information from medical records of Members received by PacifiCare from physicians, surgeons or hospitals incident to the doctor/patient or hospital/patient relationship shall be kept confidential by PacifiCare, in accordance with applicable laws, and shall not be disclosed without the consent of the Member.

7.5 Utilization Review. PacifiCare utilization procedures shall include a system of prior authorization for elective procedures, which shall include hospitalization and other procedures customarily utilized by PacifiCare in maintaining its level of care and its adherence to medical standards. The latest utilization report will be made available to GovGuam upon request.

7.6 Prompt Payment. PacifiCare shall promptly pay the undisputed portion of all claims.

7.7 Certificate of Creditable Coverage. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), PacifiCare will issue a certificate of creditable coverage with respect to a Member who terminates coverage under the Plan. Should any HIPAA fines be levied on PacifiCare because of GovGuam's late notification of a Subscriber's termination, the amount of such fines may be included in the subsequent year's renewal calculation.

VIII. MISCELLANEOUS

8.1 Binding on Successors. Each and all of the covenants, conditions and restrictions in this Agreement shall inure to the benefit of and shall be binding upon the assignees and successors in interest of PacifiCare, and assignees, transferees and other successors in interest of GovGuam.

8.2 Force Majeure. PacifiCare and GovGuam shall not be held responsible for delay or non-performance of their contractual obligations under this Agreement if such delay or non-performance of contractual obligations is caused by war, blockage, revolution, lockout, act of God, plague, epidemic, fire, flood, act of government or public enemy, or failure of the other party to timely meet its obligations under this Agreement.

8.3 Effect of Waiver. Waiver by a party of any breach of any term, covenant, warranty or condition herein contained shall not be deemed to be a waiver of such term, covenant, warranty or condition of any subsequent breach of the same or any other term, covenant, warranty or condition herein contained. The subsequent acceptance by a party of performance by the other shall not be deemed to be a waiver of any preceding breach of any term, covenant, warranty or condition of this Agreement, other than failure to perform the particular duties so accepted, regardless of knowledge of such preceding breach at the time of acceptance of such performance.

8.4 Merger and Integration. All understandings and agreements heretofore had between the parties hereto are merged in this Agreement, which alone fully and completely expresses their agreement. This Agreement is being entered into after full investigation, neither party relying upon any statement or representation not embodied in this Agreement.

8.5 Severability. In the event that any of the provisions, or portions thereof, of this Agreement are held to be unenforceable or invalid by any court of competent jurisdiction, the validity and enforceability of the remaining provisions, or portions thereof, shall not be affected thereby.

8.6 Amendments. No modification or amendment of this Agreement or any part thereof shall take effect unless agreed upon by both parties in writing.

8.7 Supersedes Prior Authorization. This Agreement executed on the date and year written below shall supersede all preceding agreements and amendments to the Government of Guam/PacifiCare Health Services Agreement.

8.8 Agreement Between PacifiCare and Its Providers. PacifiCare will include in each of its outside provider contracts, a clause holding GovGuam Members harmless in case of default in payment by PacifiCare.

8.9 Errors and Omissions Insurance. PacifiCare agrees to maintain general liability insurance with deductibles not to exceed a total of $5 million.

8.10 PacifiCare is not an insurer against, nor liable for, the negligence or other wrongful act or omission of any physician, hospital, hospital employee or other provider, or for any act or omission of any Member.

8.11 PacifiCare does not guarantee the availability of or undertake to provide any services of any third party.

8.12 In the event a Member's coverage terminates, PacifiCare will be responsible for paying all benefits incurred for services provided on or before the date of termination.

8.13 PacifiCare will fulfill the notice requirements with regard to the language and timing of the notifications as promulgated in the following U.S. federal laws: i) The Women's Health and Cancer Rights Act of 1998 and ii) The Newborns' and Mothers' Health Protection Act of 1996.

8.14 PacifiCare guarantees the negotiated rates shall remain in effect for the negotiated benefits for the contract year. However, if during the contract year either the Government of the United States or GovGuam enacts laws or issues regulations which cause an increase or decrease in coverage, provider rates or PacifiCare's other costs, the parties reserve the right on thirty (30) days notice to the other to negotiate an adjustment to the Premium to reflect the changed costs effective as of the date such change became mandatory if the party serving notice has determined that such change will increase or decrease PacifiCare's Premium under this Agreement by more than five percent (5%).

8.15 PacifiCare and GovGuam shall fully cooperate in implementing any Qualified Medical Child Support Order as defined and required by federal

law. This shall include enrolling the employee, if eligible, and the relevant child, if eligible, outside a regularly scheduled open enrollment period.

IN WITNESS whereof, the parties have set their respective signatures on the date and year written below.

PACIFICARE AS A PACIFIC

BY: _____
Joseph E. Husslein
Plan President

DATE: _____

GOVERNMENT OF GUAM

BY: _____
Director, Department of Administration

DATE: NOV 15 2002

BY: _____
Insurance Commissioner, Department of Revenue and Taxation

DATE: 11-15-02

CLEARED PER BBMR'S REVIEW

BY: _____
Director, Bureau of Budget and Management Research

DATE: 11/15/02

Department of Administration - Division of Accounts
CO3064003
NOV 25 2002
BK#: 1
By:
Travel/Contracts

APPROVED AS TO FORM:

MAIR, MAIR, SPADE & THOMPSON

Attorneys for PACIFICARE ASIA PACIFIC

BY: _____

DATE: 09/25/02

BY: _____
Acting Attorney General

DATE: NOV 15 2002

BY: _____
Honorable Carl T.C. Gutierrez
Governor of Guam

DATE: 11-18-02

0187

PCAP 0020

IN WITNESS whereof, the parties have set their respective signatures on the date and year written below.

PACIFICARE ASIA PACIFIC

BY: _____
Joseph E. Husslein
Plan President

DATE: _____

GOVERNMENT OF GUAM

BY: _____
Director, Department of Administration

DATE: _____

BY: _____
Insurance Commissioner, Department of Revenue and Taxation

DATE: _____

BY: _____
Director, Bureau of Budget and Management Research

DATE: _____

APPROVED AS TO FORM:

BY: _____
Acting Attorney General

DATE: _____

MAIR, MAIR, SPADE & THOMPSON

Attorneys for PACIFICARE ASIA PACIFIC

BY: June S. Mair

DATE: 9-25-02

BY: _____
Honorable Carl T.C. Gutierrez
Governor of Guam

DATE: _____

2003

GOVERNMENT OF GUAM/PACIFICARE ASIA PACIFIC

GROUP HEALTH INSURANCE AGREEMENT

ATTACHMENT I

PACIFICARE ASIA PACIFIC GROUP MEMBERSHIP AGREEMENT

GOVERNMENT OF GUAM/PACIFICARE ASIA PACIFIC GROUP MEMBERSHIP AGREEMENT

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PACIFICARE ASIA PACIFIC GROUP MEMBERSHIP AGREEMENT

1. ELIGIBILITY

Employees working thirty (30) hours per week or more (or full-time employees working at least 20 hours per week under the "Quality Time" program of P.L. 25-72), retirees, and survivors of retired employees receiving an annuity who reside continuously on Guam, are eligible under this Agreement. Eligible new employees shall be covered beginning the first day of the pay period following the date of enrollment. Enrollment must be within 31 days of the date of employment or else the employee must wait until the next open enrollment to join unless otherwise provided in this Agreement. No medical examination is required. Listed Eligible Dependents become effective on the same day as the Subscriber and eligible newborns will be effective on the date of birth if enrolled within 31 days of birth. Any required enrollment class change will be effective on the first day of the pay period following the date of birth. Employees of the Department of Labor's Senior Citizen Community Service Employment Program shall be eligible for coverage hereunder, provided that they are offered the option to enroll in all Health Insuring Organizations offered by GovGuam to its employees.

Any Government of Guam employee, retiree or survivor and their Eligible Dependents shall be entitled to enroll in the PacifiCare Plan in accordance with the terms of this Agreement regardless of whether he or she is confined in a hospital or other health care institution. Eligibility shall not be denied based on one or more health factors related or unrelated to such confinement.

If a Member's coverage is terminated because the Subscriber has elected to change from coverage under the PacifiCare Plan to coverage under another GovGuam Health Insuring Organization and that Member is confined in an inpatient facility covered in this Agreement on the date his or her PacifiCare coverage would otherwise have terminated, PacifiCare will make best efforts to coordinate with the Member's succeeding carrier to minimize disruption of the Member's medical care and to minimize cost to the succeeding plan.

No Eligible Dependent will be covered while in active military service.

Common-law spouse is defined as a person who is readily eligible to marry the Subscriber, without emancipation, under Guam law and who has cohabited with the Subscriber for at least the two consecutive years immediately preceding the person's proposed enrollment date.

Dependent children of the common-law spouse who are not the natural, adopted or stepchildren of the Subscriber, will become eligible for coverage under the PacifiCare Plan upon the submission of an order of adoption or proof of placement for adoption by the Subscriber within 31 days of the date the order is signed by a judge in a court of law.

A notarized PacifiCare affidavit and other proof of common-law status will be required by PacifiCare at the time of application for enrollment. Addition of a common-law spouse may only be done during open enrollment.

A child, for whom a court having jurisdiction over the parties has issued an order granting guardianship of such child to the Subscriber, is eligible for coverage subject to the following: (a) such child is identified as a dependent of the Subscriber in the current year's income tax filing under the laws of Guam, and (b) such child meets all other eligibility requirements of the Plan.

The Subscriber shall be required to provide proof of guardianship satisfactory to PacifiCare including a copy of the court order granting the guardianship for the child and the current income tax return identifying the child as a dependent. If the child is not on the Subscriber's most recent tax return, a signed affidavit stating that such child will be so identified on the current year's tax return will be accepted. On request, the Subscriber must provide a copy of such tax return, within thirty-one (31) days of filing, to PacifiCare. If the child is not therein identified as a dependent, the child will be retrospectively terminated effective October 1 of the current plan year, and the Subscriber will be liable to reimburse PacifiCare for the cost of all services which had

been covered for the child. Children under legal guardianship may only be added during open enrollment. Unborn children under guardianship are not eligible for coverage.

Benefits are discontinued for Members who are absent from the Service Area for more than 90 (ninety) consecutive days. Benefits resume upon returning to the Service Area. An exception will be made for full-time students who are enrolled Eligible Dependents. Such students are covered for emergency care and self-referrals for primary care to Participating Providers even though they remain out of the Service Area for more than 90 (ninety) consecutive days. An exception will be made for Members who have received a referral for treatment outside the Service Area and the treatment period extends past 90 (ninety) consecutive days.

If a Subscriber is court-ordered to provide medical coverage to his or her children, PacifiCare will allow such Subscriber to enroll such children in the Plan as Eligible Dependents even though they do not reside with the Subscriber or in the Service Area, provided they obey the other terms and conditions of the Plan. Benefits are limited to emergency services only when the said Eligible Dependent resides outside the Service Area.

If a Member moves to reside off-island or outside of the Service Area, benefits will be discontinued on the day he or she leaves the Service Area.

2. SPECIAL ENROLLMENT ELIGIBILITY

In addition to the eligibility rules set forth above, the following special enrollment rules shall apply to employees and Eligible Dependents.

Special Enrollment Due to Loss of Coverage

Employees working thirty (30) hours per week or more (or full-time employees working at least 20 hours per week under the "Quality Time" program of P.L. 25-72), and retirees receiving an annuity who reside continuously in Guam, will become eligible under this Agreement if all the following conditions are met:

1) The employee or retiree declined to enroll in any Group Health Insuring Organization during open enrollment or declined enrollment within 31 days of date of hire,

2) The employee or retiree had other health insurance when the declination occurred.

3) The other health insurance must be no longer in effect or available to the employee or retiree.

Employees and retirees who meet all these conditions are eligible and may enroll in the plan within 31 days of the termination of the other health coverage.

New Dependent Special Enrollment

An unenrolled employee or retiree who meets all eligibility requirements of this Agreement, including those specified in the above paragraph, "Special Enrollment Due to Loss of Coverage," may enroll himself or herself and, if desired, his or her Eligible Dependents within 31 days of acquiring a new Eligible Dependent.

3. DEFINITIONS

A. Benefit Period: The twelve-month period beginning October 1 and ending September 30 or, in the case of a Member, the period beginning on the Member's effective date of membership in the Program, and ending on the first following September 30.

B. Coinsurance: A form of cost sharing in which PacifiCare and the Member each pays a percentage of Eligible Charges. Coinsurance is applied after the collection of any Co-payments due.

C. Consulting Physician: A physician practicing in a specialty who is not a Participating Provider. The Member shall be entitled to the services of such a physician when he/she is referred to that specific Consulting Physician and the services are authorized in writing by the PacifiCare Medical Director or his or her designee.

D. Co-payments (Co-pays): A fixed dollar amount that a Member pays for a specific type of service for each visit. It is not a percentage of costs but is generally a uniform amount assessed by the type of service rendered no matter what the cost of the service.

E. Cosmetic Surgery: Surgery that is performed to alter or reshape normal structures of the body in order to change appearance.

F. **Deductible:** The amount of covered benefits that must be incurred and paid by the Member before additional covered benefits under the Plan become payable by PacifiCare.

G. **Eligible Charge** means the maximum charge which PacifiCare will reimburse the Provider for a given service.

Eligible Charges shall apply only to covered services and is further defined as follows:

i) for Participating Providers, Eligible Charges shall be the contracted rate paid by PacifiCare. In no event shall a Member be liable for any amount by which a Participating Provider's charges exceed the Eligible Charges provided the Member was referred to the Participating Provider by PacifiCare and the covered services rendered were directly related to the diagnosis and treatment for which the Member was referred. Also, in no event shall a Member be liable for any amount by which Guam Memorial Hospital's charges exceed the Eligible Charges provided the covered services rendered are covered under this Agreement.

ii) for non-Participating Providers, Eligible Charges are computed using the Medicare Participating Provider rate for the geographic area from the year prior to the date of service for professional services

iii) for non-participating hospitals, Eligible Charges are computed based upon 65% of the Guam Memorial Hospital prevailing Chargemaster as of the date of service.

iv) for all other non-Participating Provider services not identified herein, Eligible Charges shall be the same as the Usual, Customary and Reasonable charges in the geographic area. In addition, the Member shall be responsible for any amount by which the Usual, Customary and Reasonable fees in the geographic area exceed the amount PacifiCare is obligated to pay the Provider for the covered services rendered.

v) If the Eligible Charge is higher than the Provider's billed charge, the billed charge will become the Eligible Charge.

vi) In no event will the Member's Coinsurance exceed 20% of Eligible Charges.

vii) For Emergency Care received from a non-Participating Provider, the Member's total out-of-pocket costs for covered services shall not exceed what they would have been at a Participating Provider in the same geographic area.

viii) In the event that a required Co-payment or a combination of a required Co-payment and Coinsurance is in excess of Eligible Charges, the Member will be required to pay no more than the Eligible Charges.

H. **Emergency Care:** Care of an injury or acute illness when, in the judgment of the attending physician, such injury or illness requires immediate medical attention.

I. **Group:** Employer, union, associate or other which contracts with PacifiCare to provide benefits to persons employed by or affiliated with that Group.

J. **In-Service Area Out-of-Pocket Maximum:** The maximum total out-of-pocket costs, including all Deductibles,Co-payments and Coinsurance, that a Member can be held liable for during a Benefit Period for expenses incurred within the Service Area. The In-Service Area Out-of-Pocket Maximum for an individual is $2,000. The In-Service Area Out-of-Pocket maximum for a family is $6,000. Following are expenses which will not accumulate towards the In-Service Area Out-of-Pocket Maximum: (a) expenses in excess of Plan maximums, (b) expenses for non-covered services, (c) expense incurred Out-of-Service Area and (d) expenses incurred through non- Participating Providers.

K. **Life Threatening Pregnancy:** A pregnancy in which the life of the mother would be endangered if the fetus was carried to term.

L. **Medically Necessary:** Medically Necessary means that the service including supplies and medication meets all of the tests listed below:

i. Adequate. Adequate means the supply or level of service needed to provide safe and appropriate care. When applied to confinement in a hospital or other facility, this test means that the Member needs

to be confined as an inpatient due to the nature of the services rendered or due to the Member's condition and that the Member cannot receive safe and appropriate care through outpatient treatment.

ii. Appropriate. Appropriate means the service which is consistent with the diagnosis, and is otherwise in accordance with generally accepted medical practice and professionally recognized standards.

iii. Company decision. The fact that a physician may prescribe, order or recommend or approve a service does not, of itself, make it Medically Necessary and/or make the charge an allowable expenses under this Agreement, even though the service may not be specifically listed as an exclusion, without PacifiCare's determination.

iv. Not experimental. A service is not experimental when it is neither experimental in nature, for educational purposes or provided primarily for research.

v. Not for convenience. A service is not for convenience when it is not mainly for the convenience of the Member or of the Member's physician or another provider.

vi. Treatment. A treatment is one which is rendered for the treatment or diagnosis of an injury or disease, including pregnancy, birth, premature birth, congenital defects, and birth defects.

M. Outpatient Facility: An Outpatient Facility is defined as portions of a hospital facility, surgical facility, or treatment facility which provides therapeutic (both surgical and non-surgical) treatment and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. The definition of an Outpatient Facility includes all places of service identified by Medicare as an Outpatient Hospital, Ambulatory Surgical Center, Community Mental Health Center, Comprehensive Outpatient Rehabilitation Facility, and End Stage Renal Disease Treatment Facility.

N. PacifiCare Formulary: The PacifiCare Formulary is a list of over 1600 prescription drugs that physicians use as a guide when prescribing medications

for patients. The formulary plays an important role in providing safe, effective and affordable prescription drugs to Members. It also allows PacifiCare to work together with physicians and pharmacies to ensure that Members are getting the drug therapy they need. A Pharmacy and Therapeutics Committee consisting of physicians and pharmacists evaluate prescription drugs based on safety, effectiveness, quality of treatment and overall value. The committee considers first and foremost the safety and effectiveness of a medication before reviewing the cost. Participating Providers will request prior authorization for Medically Necessary non-formulary drugs. A Participating Provider may initiate the prior authorization request simply by phoning or faxing in the request. Requests are generally processed within ten minutes although a few require up to two working days when additional information is needed from the doctor.

There are dispensing limitations. Prescription Drugs will be dispensed in quantities up to a 30-day supply or one commercially prepared unit (i.e., one inhaler, one vial of ophthalmic medication, one tube of ointment, one vial of insulin). For drugs that may be habit forming, the prescription unit is set at a smaller quantity for the protection and safety of Members.

O. Participating Provider: Any Provider, including PacifiCare staff Providers, having a contractual relationship with PacifiCare for the specific GovGuam plan. Notwithstanding the fact that Guam Memorial Hospital (GMH) is not a Participating Provider, it will be treated as such for purposes of this Agreement.

P. Prescription Drug Unit: The drug amount normally dispensed on a single prescription in regular medical practice; a one month supply for an on-going disease or illness; a safe, small amount for those drugs that can be habit forming, addictive, or otherwise abusable; or one commercially prepared unit (i.e., one inhaler, one vial of ophthalmic medication, one tube of ointment, one vial of insulin). Prescription drugs are generally limited to those within the PacifiCare drug

formulary. Non-formulary prescriptions are covered when Medically Necessary and authorized by PacifiCare.

Q. **Primary Care Physician:** A Participating Provider within the Service Area which provides "front line" health care as opposed to specialty care. Generally, a Primary Care Physician is a family practitioner, internist, or pediatrician. A Primary Care Physician may also be a medical group providing primary care.

R. **Primary Dentist:** A Participating Provider within the Service Area which provides "front line" dental care as opposed to specialty dental care. Generally, a Primary Dentist is a general dentist, pedodontist or a dental group providing primary dental care.

S. **Provider:** Any professional person, organization, health facility, or other person or institution licensed by Guam or other appropriate jurisdiction to deliver or furnish health care services.

T. **Referral:** A written authorization for health care for a Member from the PacifiCare Medical Director or his or her designee to a Provider.

U. **Service Area:** Guam.

V. **Skilled Nursing Facility:** A specially qualified facility which has the staff and equipment to provide skilled nursing care as well as other related health services.

W. **Take Home Drugs:** Prescription drugs provided to the patient by the hospital after discharge. Take home drugs are not a covered benefit under this plan.

X. **UCR:** The UCR, Usual, Customary and Reasonable fee is that fee normally charged by a Participating Provider for a particular service. Usual shall mean the fee that a provider frequently charges for a given medical or dental service. Customary shall reference a fee level determined for a specific procedure to establish the maximum benefit payable. Reasonable shall reference a fee for a specific procedure that has been modified by the severity of the condition being treated and by any medical or dental complications or unusual circumstance and therefore may differ from the usual or customary fee.

4. HEALTH CARE SERVICES PROVIDED

Except if Emergency Care is required, the Member may only access care through his or her Primary Care Physician or Primary Dentist, unless otherwise specifically stated in this Agreement. Health care services provided by this Agreement will be available only when rendered by a Participating Provider, except that physician services will also be covered when rendered by a Consulting Physician when the Member has received a Referral to that Consulting Physician by his or her Primary Care Physician or Primary Dentist and that Referral has been authorized in writing by PacifiCare's Medical Management Department or PacifiCare's Medical Director. Services of authorized Consulting Physicians are subject to all terms and limitations of this Agreement.

Except if Emergency Care is required, hospital services provided by this Agreement will be available only when the Member is hospitalized under the care of a Participating Provider when such services are ordered by or performed by the Participating Provider; except that other hospital services will be available if the Member has received a Referral for such hospital services from his or her Primary Care Physician and the Referral has been authorized in writing by PacifiCare's Medical Management Department or PacifiCare's Medical Director.

5. THIRD PARTY RESPONSIBILITY (Including Worker's Compensation, uninsured and no-fault motorist insurance.)

If an injury or illness of a Member is or may have been caused by a third party and the Member has or may have a right to recover damages against a third party, PacifiCare shall not be liable to pay any benefits provided under this Agreement. However, upon execution and delivery to PacifiCare of all papers required to secure its rights of reimbursement, PacifiCare shall pay benefits in connection with such injury or illness, but such payments shall be considered only in the nature of an advance or a loan to the Member which shall be repaid from the recovery, if any, from or on behalf of such third party. PacifiCare shall be entitled to be reimbursed from any recovery to the extent of its benefit payments in connection with such injury or illness.

6. COORDINATION OF BENEFITS.

Coordination of benefits will be defined in accordance with the definition of the National Association of Insurance Commissioners (NAIC) and includes at least the following:

A. The carrier of the employee is the primary carrier.

B. In the case of a dependent child, the carrier of the parent whose birthday occurs first in the calendar year is the primary carrier.

C. Group coverage will pay primary to Medicare except as provided by U.S. Federal law or Guam law.

7. **TERMINATION.** Benefits and services under this Agreement shall terminate in the following manner:

A. For the Subscriber and enrolled Eligible Dependents, as of the first day of the pay period following the date when the Subscriber is no longer employed by GovGuam in an eligible employee classification, or as of the date this Agreement is discontinued;

B. For enrolled Eligible Dependents, as of the date the Subscriber discontinues contributions for such dependents or as of the date the Subscriber's coverage terminates;

C. For divorced spouses, as of the first day of the pay period following the divorce;

D. For "common-law" spouses, as of the first day of the pay period following the day the couple no longer cohabits.

A terminated Member, except as otherwise provided herein, shall not be eligible to obtain PacifiCare medical and dental coverage by conversion to direct payment status, except as may otherwise be required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

8. **OUT OF SERVICE AREA EMERGENCY CARE.** Emergency Care rendered outside the Service Area shall be paid at Eligible Charges. This is provided that the Member was injured or became ill while outside the Service Area and has not been continually absent from the Service Area for more than ninety (90) days prior to the commencement of such Emergency Care, unless accepted by a prior written approval by PacifiCare. The Member or his or her representative must notify PacifiCare of such Emergency Care within forty-eight (48) hours of the commencement thereof.

PacifiCare will contact any Provider that attempts to balance bill Members and will insist that all billing disputes are communicated solely to PacifiCare. PacifiCare will make every good faith effort to thus protect its Members from balance billing. In no event shall a Member be liable for any balance billing for covered services incurred at a Participating Provider or GMH provided the covered services were directly related to the treatment of the emergency and covered under this Agreement.

No Referral will be required for out of Service Area Emergency Care.

9. A. **BINDING ARBITRATION.** The Members and PacifiCare and its insurers agree that they shall attempt to resolve any controversy through the Appeals and Grievance Procedure. Should, however, the procedure discussions fail to resolve the controversy and the controversy involves a disputed amount in excess of One Thousand Dollars ($1,000.00) between the Member, or heirs-at-law or personal representative of the Member, as the case may be, in tort, contract, or otherwise, this same shall be submitted to binding arbitration. Arbitration shall be conducted and governed by the procedures set forth in the "Appeal and Grievance Procedure" which is attached to this Agreement as incorporated by reference herein.

B. **TIME LIMITS FOR FILING CLAIMS.** All claims requiring arbitration are waived and forever barred if on the date of submission of arbitration the claim, if asserted in a civil action, would be barred by the applicable statutes of limitation of Guam, or if the complainant later fails to pursue the claim with reasonable diligence in accordance with the procedures prescribed in the "Arbitration Procedure Agreement" which is attached to this Agreement and incorporated by reference herein.

10. **IN SERVICE AREA EMERGENCY CARE.** In Service Area Emergency Care shall be further defined to include conditions which preclude transportation to a Participating Provider. It specifically excludes diagnosis, treatment, or medical care obtained solely at the discretion of and for the convenience of the Member from sources other than Participating Providers. In the event of a claim for In Service Area Emergency Care, provided the PacifiCare business office is notified within forty-eight (48) hours, PacifiCare shall bear said costs at a rate equal to Eligible Charges for reasonable services. It shall

be the responsibility of the PacifiCare's Medical Management Department or PacifiCare Medical Director to determine whether said claim for In Service Area Emergency Care is valid. In Service Area Emergency Care provided by non-Participating Providers must be transferred to the care of a Participating Provider within forty-eight (48) hours for continued coverage.

No Referral will be required for In Service Area Emergency Care. Also, in no event shall a Member be liable for any balance billing for covered services incurred at a Participating Provider or GMH provided the covered services were directly related to the treatment of the emergency and covered under this Agreement.

11. **SELECTION OF PRIMARY CARE PHYSICIAN AND/OR PRIMARY DENTIST.** Each Member must select a Participating Provider who is a Primary Care Physician and/or a Primary Dentist within the Service Area. The Member will be considered to have selected a Primary Care Physician or Primary Dentist by accessing that Provider. If a Member does not select a Primary Care Physician and/or a Primary Dentist, such selection will be made by PacifiCare. A Member may change this selection by notifying the PacifiCare Customer Service Department to be effective on the first day of the month following notification.

12. **EFFECTIVE DATE OF AGREEMENT.** New employees and their Eligible Dependents may be enrolled according to the eligibility rules herein described. A person who is already employed may be enrolled only during designated open enrollment or special enrollment periods as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

13. **RETIREES** who are Medicare eligible and receiving Social Security income benefits, must enroll in all Medicare options for which they are eligible. Under no circumstances will anyone be required to enroll in Medicare Part A or Medicare Part B unless it is available to him or her at no cost. Should PacifiCare offer to pay premiums for any retiree eligible to receive Medicare benefits, Member agrees to complete all necessary enrollment processes and documentation required for program participation. A Member who fails to enroll in all portions of the Medicare program open to him or her and who refuses to sign

or maintain in effect the necessary releases, shall be terminated for all rights and benefits under this Agreement as of the first day of the pay period following the date of refusal to enroll or maintain participation in Medicare.

14. **MEMBERS**, who are Medicare eligible as a result of end stage renal disease, must enroll in all Medicare options for which they are eligible. Under no circumstances will anyone be required to enroll in Medicare Part A or Medicare Part B unless it is available to him or her at no cost. Should PacifiCare offer to pay premiums for any Member eligible to receive Medicare benefits, Member agrees to complete all necessary enrollment processes and documentation required for program participation. A Member who fails to enroll in all portions of the Medicare program open to him or her and who refuses to sign or maintain in effect the necessary releases, shall be terminated for all rights and benefits under this Agreement as of the first day of the pay period following the date of refusal to enroll or maintain participation in Medicare.

15. **SPECIAL CHILDREN'S RIGHTS.** In accordance with Public Law 22-101, Section 95101, and notwithstanding any other provision of this Agreement, no child whose parent is a Subscriber shall be denied coverage for any of the following reasons:

I. The child was born out of wedlock.
II. The child is not claimed as a dependent on the parent's Guam tax return.
III. The child does not reside with the parent in the Service Area.
IV. The child has a pre-existing or excluded medical condition.
V. The child is adopted or the subject of adoption proceedings.

16. If a Member incurs an expense for eligible benefits while covered and for which the Member is eligible for and entitled to benefits under Medicare, then PacifiCare will reduce benefits by the amount Medicare would pay, and PacifiCare will not provide any benefit if the amount Medicare would pay equals or exceeds its benefit. If any Member is eligible for and not enrolled in the entire Medicare program but is receiving income benefits from Social Security, PacifiCare will provide no benefits on behalf of that Member. Under no circumstances will anyone be required to enroll in Medicare Part A in order to receive benefits under the plan, unless Medicare Part A is available to him or her at no cost, but

shall be required to enroll in Part B, subject to the Government of Guam or some other entity paying the Part B premium. A Member who fails to enroll in all portions of the Medicare Program open to him or her and who refuses to sign or maintain in effect the necessary releases, shall be terminated for all rights and benefits under this Agreement as of the first day of the pay period following the date of refusal to enroll or maintain participation in Medicare.

17. PacifiCare's dialysis network for the Government of Guam 2002-2003 benefit period is the Guam Memorial Hospital (GMH). Given the Government of Guam's concern, specifically related to the capacity at the Guam Memorial Hospital (GMH), PacifiCare will allow current PacifiCare Members, established and actively receiving care at non-GMH dialysis providers, to continue to receive care with theses non-participating dialysis providers for the 2002-2003 benefit period. Member's out-of-pocket expenses incurred during the 2002-2003 benefit period at these non-participating dialysis providers shall not apply to the Member's health plan out-of-pocket maximum.

Any new PacifiCare members, or existing PacifiCare Members newly diagnosed and in need of dialysis treatment during the 2002-2003 benefit period, shall be required to access dialysis services consistent with PacifiCare's dialysis network for that benefit period; specifically and solely Guam Memorial Hospital.

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GOVERNMENT OF GUAM/PACIFICARE ASIA PACIFIC

GROUP HEALTH INSURANCE AGREEMENT

ATTACHMENT II

PACIFICARE ASIA PACIFIC APPEALS AND GRIEVANCE PROCEDURE

0206

PCAP 0039

PACIFICARE ASIA PACIFIC

APPEALS AND GRIEVANCE PROCEDURE

GOVERNMENT OF GUAM 2002-2003 AGREEMENT

PacifiCare will make every attempt to resolve any dissatisfaction a Member may have. However, if the solution is unacceptable to the Member, he or she has the right to submit a formal appeal through this Appeals & Grievance Procedure The PacifiCare Customer Service Department will serve as the Member's primary contact and will be available to assist the Member in the Appeals & Grievance procedure.

GRIEVANCE

A PacifiCare Member has the right to file a complaint—also called a grievance—about problems he or she observes or experiences, including:

- Complaints about the quality of services received;
- Complaints regarding such issues as office waiting times, physician behavior, adequacy of facilities, or other similar Member concerns;

PacifiCare will attempt to resolve any complaint that the Member might have. PacifiCare will encourage the informal resolution of complaints (i.e., over the telephone through the Customer Service Department), especially if such complaints result from misinformation, misunderstanding or lack of information. However, if the complaint cannot be resolved in this manner, a more formal Member grievance procedure is available.

To use the formal grievance procedure, the Member must submit the grievance in writing to the Customer Service Department. PacifiCare will write to the Member to let him or her know how the concern has been addressed within thirty (30) days of

receiving the written grievance. In some instances, PacifiCare will need additional time to address a concern. If additional time is needed, PacifiCare will keep the Member informed regarding the status of the grievance.

However, complaints about a decision regarding payment or provision of Covered Services that a Member believes are covered and should be provided or paid for by PacifiCare must be appealed through the formal appeals procedure.

To use the formal appeals procedure, a Member must submit his or her grievance in writing to the Customer Service Department.

APPEAL

PacifiCare Members have the right to appeal any decision about PacifiCare's payment for or failure to arrange for or continue for what he or she believes are Covered Services.

WHO MAY FILE AN APPEAL

1. The Member may file an appeal.

2. Someone else may file the appeal for the Member or on the Member's behalf.

The Member may appoint an individual to act as his or her representative to file the appeal by following the steps below:

a. A Member must give PacifiCare his or her name and a statement, which appoints an individual as his or her representative. (Note: The Member may appoint a physician or a provider.) For example: "I [Member's name] appoint [name of representative] to act as my representative in requesting an appeal from PacifiCare regarding the denial or discontinuation of medical services.

b. The Member must sign and date the statement.

c. The Member's representative must also sign and date this statement.

d. The Member must include this signed statement with the appeal.

3. A Non-Primary Care Physician may file a standard appeal of a denied claim if he/she completes a waiver of liability statement, which says he/she will not bill the Member regardless of outcome of the appeal.

SUPPORT FOR THE APPEAL

The Member is not required to submit additional information to support the request for services or payment for services already received or request for reconsideration (appeal). PacifiCare is responsible for gathering all necessary medical or dental information. However, it may be helpful to include additional information to clarify or support the request. For example, the Member may want to include in the appeal request information such as medical or dental records or physician opinions in support of the request. To obtain medical or dental records, the Member may send a written request to his or her Primary Care Physician or Primary Dentist. If a Member's medical or dental records from a Specialist are not included in the medical or dental records from the Member's Primary Care Physician or Primary Dentist, the Member may need to make a separate request to the Specialist who provided medical or dental services to him or her.

The Member may provide additional information in person or in writing and may call the PacifiCare Customer Service Department for additional information on the procedures for submitting evidence.

APPEAL PROCEDURE

First Level Review

Within ninety (90) calendar days of having received a denial of a claim or service, the Member may submit a request for consideration at the First Level Review to the PacifiCare Customer Service Department.

Once the request has been received within the 90-day timeframe, the following steps will occur:

1. PacifiCare will send the Member a letter acknowledging receipt of the request for reconsideration (appeal) at the First Level Review.
2. PacifiCare will notify the Member in writing of the decision made at the First Level Review within thirty (30) calendar days of receipt of the request for reconsideration at this level.
3. If the decision is a denial, the letter must state the reasons for the denial and inform the Member of his or her right to reconsideration at the Second Level Review. *Note: If the Member does not receive a letter with the First Level Review decision within thirty (30) days, he or she may assume the decision is negative and file for reconsideration at the Second Level Review.*
4. If the appeal was denied at the First Level Review on the basis of medical necessity or experimental/investigational treatment AND where the cost of the care or service is at least $500.00, the Member will be given the option of reconsideration at the Second Level Review or through Independent External Review (IER). If a Member selects the Second Level Review, he or she will not be allowed to request for Independent External Review at any future point in the appeal process. Likewise, if the Member selects the Independent External Review, he or she will not be allowed to request for the Second Level Review at any future point in the appeals process.

Second Level Review

Within ninety (90) calendar days of having received a denial at the First Level Review, the Member may submit a request for reconsideration at the Second Level Review to the PacifiCare Customer Service department. The PacifiCare Appeals & Grievance Committee who will be reconsidering the appeal at the Second Level Review is comprised of persons not involved in the First Level Review. If the Member decides to proceed with the Second Level Review, the Member is given two options:

1. The Member may choose to have the appeal reconsidered at the Second Level Review WITHOUT a formal panel hearing, or
2. The Member or his or her authorized representative may prefer to present his or her appeal in person at the Second Level Review WITH a formal panel hearing with the PacifiCare Appeals & Grievance Committee.

Once the request has been received within the 90-day timeframe, the following steps will occur:

1. PacifiCare will send the Member a letter acknowledging receipt of the request for reconsideration at the Second Level Review with or without a formal panel hearing with the PacifiCare Appeals & Grievance Committee.
2. If the Member requests for the Second Level Review WITHOUT a formal panel hearing, he or she may still submit relevant facts and/or additional evidence in support of his or her appeal. The appeal will be heard by the PacifiCare Appeals & Grievance Committee without the Member's presence.
3. If the Member requests for the Second Level Review WITH a formal panel hearing, he or she will be notified in the acknowledgement letter of the date and time for the

next panel hearing. The Member or his or her authorized representative may then present the appeal in person and any additional relevant information or evidence may also be presented.

4. In either case, PacifiCare will notify the Member in writing of the decision made at the Second Level Review within thirty (30) calendar days of receipt of the request for reconsideration at this level.

Independent External Review (IER)

Within ninety (90) calendar days of having received a denial at the First Level Review, the Member may submit a request for reconsideration through Independent External Review (IER) to the PacifiCare Customer Service department. PacifiCare decisions that are eligible for review by an independent review organization (IRO) are those where PacifiCare decided that the request for care or service was not medically necessary or was considered experimental or investigational AND where the cost of the care or service is at least $500.

Once the request has been received within the 90-day timeframe, the following steps will occur:

1. PacifiCare will forward the Member's appeal file to the IRO contracted to provide external physician review related to issues of medical necessity. If he or she would like to submit additional information regarding the appeal, the Member may send it to the PacifiCare Customer Service department or directly to the contracted IRO.
2. PacifiCare will notify the Member in writing of the determination made by the IRO within thirty (30) calendar days of receipt of the request for reconsideration at this level.

If the Member is dissatisfied with the decision rendered at the Second Level Review or through Independent External Review, the Member has the right to request binding arbitration to resolve the dispute. Members understand that by enrolling in PacifiCare, they agree to give up their constitutional right to have any dispute decided in a court of law before a jury.

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GOVERNMENT OF GUAM/PACIFICARE ASIA PACIFIC

GROUP HEALTH INSURANCE AGREEMENT

ATTACHMENT III

PACIFICARE ASIA PACIFIC ARBITRATION PROCEDURE

PACIFICARE ASIA PACIFIC ARBITRATION PROCEDURE

GOVERNMENT OF GUAM 2002-2003 CONTRACT

SECTION 1. ARBITRATION PROCEDURE

"Arbitration"

1.01. Any dispute or controversy between the parties arising under this Agreement shall be submitted to binding arbitration. Arbitration is initiated and required by giving written notice specifying the issues to be arbitrated. If a court proceeding is already pending on any matter concerning which a notice of arbitration is given, then the notice of arbitration is ineffective unless given within ten (10) days after service of process of the court proceeding on the person demanding arbitration. The arbitration shall be in conformity with and subject to the following rules and procedures:

1.01.01. Appointment of Arbitrators. Each party shall appoint one arbitrator and notify the other of such appointment within ten (10) working days after service of the written notice of arbitration. If a party fails to appoint an arbitrator within the ten (10) working days, the other party shall be entitled to designate two arbitrators. The two arbitrators shall select a third within five (5) working days after the appointment of the second arbitrator, and the three so appointed shall constitute an arbitration board, a decision by a majority of which shall be binding on the arbitrators and on the parties on all matters to be considered, including but not limited to questions of procedure and rules of evidence. If the first two arbitrators fail to agree on the third within such five (5) working day period, they or either of them shall apply to the Superior Court of Guam, who shall select the third arbitrator within five (5) working days of such application.

1.01.02. Qualifications of Arbitrators. The arbitrators shall be impartial. Prior to accepting an appointment, the arbitrator shall make a full and complete disclosure to all parties of any circumstance likely to affect impartiality, including all information relating to any financial, business or personal interests he or she may have with either party or its representatives. Upon receipt of such information, the party or parties making the appointment shall immediately replace the arbitrator. If the arbitrator determines he or she has nothing to disclose that could affect his or her impartiality, he or she shall so state in writing to each party. Should the selection of either arbitrator give rise to an objection by either party for any reason, the party must present all the objections in writing, stating the reasons therefor, to the nominating party within five (5) working days from the date of receipt of the arbitrator's disclosure statement. If the nominating party disputes the objections, then the issue will be resolved by a judge of the Superior Court of Guam, whose determination shall be conclusive. Prior to accepting an appointment, the third arbitrator shall make the same full and complete disclosure to all parties and arbitrators of any circumstances likely to affect impartiality and

if either party objects to the third arbitrator for any reason, the same process as for party-selected arbitrators applies.

1.01.03. Vacancy. The party or parties making the appointment are authorized to substitute another arbitrator if a vacancy occurs or if an appointed arbitrator is unable to serve promptly. The same qualification and procedures as set forth in Section 1.01.02 shall apply in the substitution of arbitrators.

1.01.04. Time and Place of Hearing. The arbitrators shall fix a mutually convenient time and place of hearing to be held no less than thirty (30) days, but no more than

forty-five (45) days after arbitration is initiated, notice of which must be given at least ten (10) days in advance. Such notice may be given orally.

1.01.05. Representation by Counsel. Any party may be represented at the hearing by counsel or other representative or representatives.

1.01.06. Attendance at Hearings. Persons having a direct interest in the arbitration are entitled to attend the hearing. The arbitrators may require the retirement of any witness during the testimony of other witnesses. The arbitrators shall determine whether any other person may attend the hearing.

1.01.07. Adjournments. Hearings shall be adjourned by the arbitrators only for good cause, and an appropriate fee will be charged by the arbitrators against the party causing the adjournment.

1.01.08. Oaths. The arbitrators shall require witnesses to testify under oath.

1.01.09. No stenographic record by arbitrators. There shall be no stenographic records of the proceedings kept by the arbitrators but a party may, at its expense, keep such a record.

1.01.10. No contacts. Once an arbitrator has been selected, neither party may have any ex parte communications with that arbitrator.

1.01.11. Decision Based on Issues. The award of the arbitrators shall be based on only the issues specified in the notice provided in Section 1.01 to the arbitrators.

1.01.12. Proceedings. The hearing shall be conducted by the arbitrators in whatever manner will most expeditiously permit full presentation of the evidence and the arguments of the parties. The arbitrators shall cause appropriate minutes of the proceedings to be kept. Normally, the hearing shall be completed within one (1) day. In unusual circumstances

and for good cause shown, the arbitrators may schedule an additional hearing, within five (5) days.

1.01.13. Evidence. The arbitrators shall be the sole judge of the relevancy and materiality of the evidence offered.

1.01.13.1. Witnesses. No party may depose the other's expert. The parties shall exchange summaries of the expert testimony to be presented no less than (20) days before the hearing. The parties shall exchange witness lists no less than (10) days before the hearing. No person not named on a witness list may be called to testify.

1.01.14. Arbitration in the Absence of a Party. The arbitration may proceed in the absence of any party who, after due notice, fails to be present. An award shall not be made solely on the default of a party. The arbitrators shall require the attending party to submit supporting evidence.

1.01.15. Arbitration Memoranda. The parties shall file and serve written arbitration memoranda with the arbitrators, no less than ten (10) working days preceding the day selected for the arbitration hearing, containing: A summary of the issues to be reviewed; a statement of the party's position; a list of witnesses; exhibits; any physical evidence that will be submitted to the panel (including, but not limited to, affidavits and documents); and a summary of any authority, if applicable, which supports the party's position. Once the arbitrators have received both parties' memoranda, they shall simultaneously serve them on the opposite party.

1.01.16. Evidence by Affidavit and Filing of Documents. The arbitrators may receive and consider evidence in the form of an affidavit, but shall give appropriate weight to any objections made. All documents to be considered by the arbitrators shall be filed at the hearing.

There shall be no post hearing briefing or submission, except by stipulation of the parties, or by the request of the arbitrators.

1.01.17. Close of Hearings. The arbitrators shall ask whether parties have any further proofs to offer or witnesses to be heard. Upon receiving negative replies, the arbitrators shall declare and note the hearing closed. The third arbitrator selected shall keep a copy of the minutes of the proceedings, and of the affidavits and other documentary material presented at the hearing(s) for a period of not less than ninety (90) days.

1.01.18. Waiver of Rules. Any party who proceeds with the arbitration provisions after knowledge that any provision or requirement of these rules has not been complied with and who fails to state his objections thereto in writing shall be deemed to have waived his right to object.

1.01.19. Service of Notice. Any papers or process necessary or proper for the initiation or continuation of an arbitration under these arbitration provisions and for any court action in connection therewith or for the entry of judgement on an award made thereunder, may be served upon such party (i) by mail addressed to such party or its attorney at its last known address, or (ii) by personal service, or (iii) as otherwise provided in these rules.

1.01.20. Time of Award. The award shall be rendered promptly by the arbitrators and, unless otherwise agreed by the parties, not later than five (5) working days from the date of the closing of the hearing.

1.01.21. Form of Award. The award shall be in writing and shall be signed by the arbitrators. If the arbitrators determine that an opinion is necessary, it shall be in summary form.

1.01.22. Delivery of Award to Parties. The parties shall accept as legal delivery of the award the placing of the award or a true copy thereof in the mail by the arbitrators

addressed to such party at its last known address or to its attorney, or personal service of the award, or the filing of the award in any manner which may be prescribed by law.

1.01.23. Expenses. The expenses of witnesses for either side shall be paid by the party producing such witnesses. Each party shall pay for the expense of its selected arbitrator. The cost of the third arbitrator and the other costs of arbitration shall be equally divided between the two parties. In establishing the cost of arbitration, the hourly fees for an arbitrator shall be reasonable, and shall be approved by each party prior to the arbritrators acceptance of appointment and those fees shall be be set forth in a written agreement between the parties. Any dispute concerning the billings submitted shall be resolved by discussions between the parties and the arbitrators and if they are unable to reach agreement, then by a Judge of the Superior Court of Guam.

1.01.24. Rules Binding. The arbitrators shall be bound by this Agreement. Pleadings in any action pending on the same matter shall be deemed amended to limit the issues, if any, to those not covered by the arbitration. Each party covenants and agrees to abide by, perform, accept and fulfill the award or finding concerning the matter(s) submitted to the arbitration, as allowed by law.

Section 2. EFFECT OF AMENDMENT

The parties acknowledge that the revisions to the arbitration procedures made herein do not change the effect of the decision of the District Court of Guam Appellate Division in Civil Case No. 90-00014A on the Agreement. In addition, Chapter 32 of Title 5 of the Guam Code Annotated, more commonly referred to as the "Deceptive Trade Practices--Consumer Protection Act", states at Section 32104(c) that an agreement to arbitrate constitutes an important waiver of the right of access to the courts which must be expressly waived in writing. In consideration of

this amendment to the Agreement, the Government of Guam agrees that the arbitration procedure herein shall continue to be a part of the Agreement each year that the Agreement renews. The Government of Guam does hereby expressly waive any application of the provisions of Section 32104(c) of the Deceptive Trade Practice–Consumer Protection Act to the Arbitration Procedures of the Agreement, as now amended, or as amended in the future. The signatures of the parties' attorneys below confirm that both parties were represented by legal counsel in the procuring of this agreement to amend the Agreement.

2003

GOVERNMENT OF GUAM/PACIFICARE ASIA PACIFIC

GROUP HEALTH INSURANCE AGREEMENT

ATTACHMENT V

PACIFICARE ASIA PACIFIC UTILIZATION

GOVERNMENT OF GUAM/PACIFICARE ASIA PACIFIC UTILIZATION

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PacifiCare•Asia Pacific

Policy and Procedure ***Division/Department:*** **Medical Management**

SUBJECT: Prior Authorization Approvals

POLICY NO.: MM 03 **DATE ISSUED: 5-8-01** **PAGE 1 OF 1**

REVISION DATES:

AUTHORIZED BY: Mary Kleschen, MD, MPH, Medical Director **DATE: 5-8-01**

POLICY: Qualified health professionals assess the clinical information used to support Medical Management decisions.

PURPOSE: To ensure that appropriately licensed health professional supervise all the review decisions.

PROCEDURE:

1. Senior Authorization coordinators may initiate approvals when care is received on-island as an outpatient.

2. Senior Authorization coordinators will apply InterQual or other determination criteria based on the target review list and as deemed necessary by coordinator.

3. The Prior Authorization (PA) and all determination criteria outcomes are forwarded to the Authorization nurse for review and final approval of on-island, outpatient care.

4. Authorization nurses must issue approvals for all inpatient and all off-island care.

5. Authorization nurses will request needed documentation, apply appropriate determination criteria and make approval decisions based on established medical practices.

6. If criteria is not met, or any questions exist, the PA must be forwarded to the Medical Director for review and determination based on established medical criteria.

Reference: [P&P on "Denials" and "Escalation"]

0224

PCAP 0057

PacifiCare® Asia Pacific

Policy and Procedure ***Division/Department:*** **Medical Management**

SUBJECT: **Coordination of Transition and Continuity of Care Services for New Members, or Members Associated with a Physician or Medical Group Phase Out**

POLICY NO.: MM 06 **DATE ISSUED: 5-8-01** **PAGE 1 OF 8**

REVISION DATES:

AUTHORIZED BY: Mary Kleschen, MD, MPH, Medical Director **DATE: 5-8-01**

POLICY: To establish a process to facilitate continuity and/or transition of care for newly insured PacifiCare (PCAP) and for members associated with a physician or Medical Group being phased out as a contracting provider. This process also addresses those members who require services during a current episode of care from a non-contracting provider.

PURPOSE: When an employer group changes insurance carriers to PacifiCare Asia Pacific, or when a PCAP physician or Medical Group is being phased out as a contracting provider, appropriate transition of care will allow the member to receive the medical services required to ensure continuity of care during the transition period until the episode of care is completed. This process ensures reasonable consideration is given to the potential clinical effects a change in provider would have on the member's treatment or condition. The receiving group has the option of accepting the previously approved authorization or may re-evaluate for medical necessity. If the group decides to re-evaluate the request for medical necessity the decision must be made within two (2) business days.

The six areas of Transition of Care are:

1. Third trimester pregnancy
2. Transition of care to a new mental health provider
3. Transition of care during Medical Group or physician phase out
4. Transition of care when member request transfer to new physician or medical group
5. Transition of care to PCAP from member's previous carrier
6. Special Circumstances

CRITERIA FOR CURRENT EPISODE OF CARE:

1. Documented pregnancy when member is in her third trimester as of the date of eligibility/phase-out, and is established with an obstetrician.

2. Surgeries already scheduled within four weeks of the effective/phase-out date.

3. Post-operative visits following surgery for the duration of the global period associated with the procedure. **All visits must be included in the global fee.** Additional follow-up by the surgeon will be reviewed on a case-by-case basis.

4. Acute inpatient care, skilled care or rehabilitation until discharge has been completed and up to two (2) weeks post-discharge.

5. Outpatient mental health treatment programs in process or near completion. Three (3) visits with the non-contracting provider will be authorized over a sixty- (60) day period while the member is transitioned to a contracted provider.

6. Completion of current cycle of chemotherapy up to a one (1) month course. Additional chemotherapy can be provided by the member's new Medical Group or physician.

7. Organ transplants when the member is already on a waiting list at a transplant center. Records are reviewed by PacifiCare's Medical Director to ensure member meets PacifiCare criteria for transplant.

8. All other issues are reviewed on a case-by-case basis.

9. Continuation of DME and HH Services up to 30 days.

10. Continuity of Care requirements for a member of "Special Circumstance" as defined below may extend up to the following time periods as applicable:
    a) 90 days after the date of termination of the contracted physician
    b) 9 months for a member with a terminal illness
    c) Six weeks post delivery if the member is past 24 weeks at the time of the physician's termination.

DEFINITION: **Special Circumstance** – a condition such that the treating physician or provider reasonably believes that discontinuing care by the treating physician or provider could cause harm to the patient.

PROCEDURE:

1.0 Members are identified through one or more of the following methods:

1.1 Referral from PCAP Sales and Marketing

1.2 Contact from employer or member

1.3 Referral from Customer Services

1.4 Referral from PCAP Network Management for physician and/or Medical Group phase-out.

2.0 All referrals are submitted to the Medical Management department via written request or by direct contact.

3.0 Upon receipt of the request, eligibility for transition care benefits is verified by one or more of the following:

3.1 Contact with treating physician/physicians;

3.1.1. review of medical records, if necessary,
3.1.2. verification of anticipated delivery date if member is in third trimester of pregnancy;

3.2 Written or verbal contact with Marketing personnel;

3.3 Written or verbal contact with Network Management;

3.3.1. verification of physician and/or Medical Group's phase-out date.

3.4 Contact with member or potential member.

Transition of Care- Third Trimester Pregnancy (Other than Special Circumstance)

4.0 Members in their third trimester of pregnancy, who are new to the plan or involved in a physician and/or Medical Group phase-out, will be allowed to

remain with a non-contracting obstetrician through delivery and six (6) weeks post-delivery, if the obstetrician is willing to accept a contract rate and uses a contracted hospital for the delivery.

4.1 If the obstetrician is not on staff with any of PacifiCare's contracted hospitals and is not willing to obtain temporary privileges at a contracting hospital, PCAP or the designated Authorization nurse will assist the member in transitioning to a new obstetrician;

4.2 Delivery at a non-contracting hospital will not be offered to the member.

5.0 If the obstetrician is contracted with a PCAP Medical Group, the Case Manager will contact the member and facilitate member's transfer to that Medical Group, if possible.

6.0 If the obstetrician is not contracted with another PCAP Medical Group, but will deliver at a contracted hospital, a case rate or contract will be established by the PCAP Network Management department.

6.1 Authorization information will be entered into Facets.

7.0 The Authorization Nurse will contact the new Medial Group and provide an overview of issues involved in member's transition of care.

7.1 Hospital services must be authorized by the Medical Management department.

7.2 All non-pregnancy care during the pregnancy and all post delivery care must be managed by the new Medical Group.

7.3 Pediatrician must be contracted with PCAP and/or the member's chosen Medical Group.

8.0 The PCAP Case Manager will send a letter to the member and to the obstetrician identifying member and physician responsibilities pertaining to this extra-contractual benefit if the member is assigned to a non-delegated provider.

8.1 A copy of this letter is forwarded to selected personnel within PCAP Customer Services, Provider Contract Administration, Network Management and Claims.

8.2 Each delegated group must develop a process to identify the member and physician responsibilities if an extra contractual arrangement is negotiated.

Transition of Care – New Mental Health Provider

9.0 Members new to PCAP, or members involved in a phase-out of a Medical Group who are undergoing inpatient or outpatient mental health treatment by a non-contracting provider, will be evaluated to determine the clinical effect a change in provider will have on therapeutic progress.

10.0 If required, the PCAPAuthorization Nurse will assist in facilitating communication between the two providers to ensure a smooth transition of care to the member's new provider. Should medical records or patient information be required to complete this process, the Authorization Nurse will assure that proper consent for release of information has been obtained from the member in accordance with PacifiCare's Confidentiality Policy and applicable state and federal laws or regulations.

10.1 Once it is determined that the member intends to transition to a new contracting provider, the Authorization Nurse may assist the transition process by authorizing up to three (3) visits at PCAP rates with the non-contracting provider, as necessary over a sixty (60) day period beginning with the member's effective date with PCAP or his/her new Medical Group.

10.1.1 Authorization for emergency mental health service may be provided in addition to the above as determined by the PCAP Medical Director, after review of the overall issues.

Transition of Care – Medical Group or Physician Phase-Out (Other than Special Circumstance)

11.0 Upon receipt of notification of a Medial Group/IPA or physician term from Network Management, the Authorization nurse will contact the Medical Group being phased out, indicating data required on contracted providers and outstanding authorizations.

11.1 If response is not forthcoming, the Authorization Nurse will contact the Network Manager for assistance.

12.0 The Authorization Nurse collaborates with the receiving MG to identify current inpatient; rehabilitation and SNF admissions to ascertain the need for continued services after termination date.

13.0 The member will be notified by letter of the phase-out in accordance with the notification timeframes set forth by the Health Care Financing Administration (HCFA).

13.1 Instructions regarding continuity and transition of care will be addressed in the notification letter. (See Attachment: Transition of Care Form and Transition and Continuity of Care Overview)

14.0 Requests for Continuity or Transition of Care will be reviewed by the PCAP Medical Management department, who will be responsible for obtaining required information.

14.1 Required information includes, and is not limited to, the following:

14.1.1 name/phone number of existing PCP and specialist
14.1.2 name of newly selected PCP and Medical Group
14.1.3 nature of illness
14.1.4 type of procedure
14.1.5 Facility providing services

15.0 The PCAP Medical Management department will evaluate the medical needs of the member and, if continued care by a non-contracting provider is deemed reasonable and necessary, the Authorization Nurse will:

15.1 Contact the Medical Director and provide overview of issues involved in member's transition of care;

15.2 Coordinate services provided by member's existing providers with new Medical Group/PCAP contracted providers as much as possible;

15.2.1 obtain a case rate through PCAP Provider Services for services authorized by PCAP, to be provided by non-contracting providers;

16. 0 The member will be covered for services rendered by the non-contracting provider until such time as PCAP or the new Medical Group can transition the member's care to his/her contracting providers or until acute episode of care is concluded, whichever occurs first.

16.1 PCAP will be financially responsible for all of the member's care after the member is transitioned to a contracted provider, or as soon as the acute care episode is completed;

16.1.1 the Medical Group must provide comparable services if the member is transitioned to contracting providers, as medically indicated.

17.0 If problems/trends are identified during the phase out process, the Authorization nurse will request assistance from the following:

17.1 Medical Director for medical issues.

17.2 Network Management for contractual issues.

Transition of Care – From Previous Carrier to PacifiCare

18.0 Members who are newly effective with PCAP and requiring continuing care from a non-contracting provider will be offered the opportunity to request transition of care benefits.

18.1 Member must obtain a Transition of Care form from their employer and forward the completed form to the Health Care Quality Department.

19.0 The Authorization Nurse will review the completed Transition of Care form to determine the urgency of the request and member's eligibility for assistance with transition of care.

19.1 The attending physician may be contacted to validate the diagnosis and treatment plan.

20.0 If the information provided indicates the member requires assistance with transition of care, the appropriate Authorization Nurse will contact the member to obtain an overview of issues. If the member's non-contracting provider is affiliated with another PacifiCare Medical Group, Customer Service will assist the member in transitioning to a new Medical Group.

20.1 The PCAP Case Manager will coordinate services provided by member's existing providers with contracting providers associated with the member's assigned Medical Group or PCAP as much as possible.

20.1.1 The Authorization Nurse will obtain a case rate for the services to be provided by the non-contracting provider through direct contact with the provider, or through PCAP's Provider Services department, if necessary;

20.1.1.1 The information will be entered into the appropriate

Authorization system.

21.0 If the information provided indicates the member does not require assistance with transition of care, a denial letter will be sent to the member.

21.1 Member may appeal the denial for continuity of care only after the date he/she becomes eligible with PCAP.

Special Circumstance

22.0 A contracting physician that is terminating from PacifiCare may request to continue treating a member if the treating physician believes that discontinuing care by the treating physician or provider could cause harm to the patient. The member may have a disability, acute condition, and life-threatening illness or is past the twenty-fourth week of pregnancy.

22.1 The request must be made by the treating physician, not the member.

22.1 The treating physician must request that the enrollee be permitted to continue treatment under the physician or provider's care.

22.1 The physician must agree not to seek payment from the patient of any amounts for which the member would not be responsible if the physician or provider were contracted with PacifiCare.

23.0 If the terminating physician is permitted to continue providing treatment under special circumstances PacifiCare is not obligated to reimburse the physician beyond:

a) The 90th day after the effective date of the physician's termination
b) Nine months for members diagnosed with a terminal illness
c) Six weeks post delivery if member at the time of the physician's termination is past the 24th week of pregnancy. The agreement will extend through delivery of the child, immediate postpartum care and the first six-week of delivery.

Approvals will be based on PCAP standardized, accepted criteria.

0232

PCAP 0065

PacifiCare® Asia Pacific

Policy and Procedure ***Division/Department:*** **Medical Management**

SUBJECT: Denial of Services and Notification of Non-Coverage

POLICY NO.: MM 07 **DATE ISSUED: 5-8-01** **PAGE 1 OF 2**

REVISION DATES:

AUTHORIZED BY: Mary Kleschen, MD, MPH, Medical Director **DATE: 5-8-01**

POLICY: Denial or modification of services will be reviewed and approved by the Medical Director. Notification will be made in writing and processed in a timely manner.

PURPOSE: To provide written notification to the member and the requesting provider when health services or supplies are denied or modified and to inform the member and attending physician of his/her right to appeal the decision.

PROCEDURE:

1. Denials may be issued for lack of medical necessity, non-contracted provider, non-covered benefit, member not eligible or member has met plan maximum.

2. Authorization coordinators may initiate denials on basis of the following:

   A. non-covered benefit
   B. ineligible member
   C. plan maximum

3. Denials for medical necessity and non-contracted provider must be forwarded to and/or initiated by an Authorization Nurse or Concurrent Review Nurse.

4. The Nurse collects all information and determination criteria on all proposed denials and reviews with the Medical Director on a daily basis, as needed.

5. The Medical Director makes a decision on all requests.

6. If a denial decision is made, the Authorization Coordinator will issue a denial letter for Medical Director's signature.

7. The denial decision may be communicated to the provider by the Authorization Nurse by phone.

8. The member and the requesting provider will be sent a denial letter with an explanation of their right to appeal the decision within two (2) working days from date of decision.

9. If a modification is made, the Medical Director will modify the original authorization request with signature. The request will be faxed to requesting provider and the member notified by phone.

10. All denial notifications will be sent via certified mail, return receipt requested. Denial notifications for hospitalized patients may be hand delivered by the concurrent review nurses with a patient or family member signature acknowledging receipt obtained at time of delivery.

11. Denial letters will be copied to the member, the PCP, the requesting provider and the Claims department. A copy is retained by the Medical Management department in the Denial Folder in alphabetical order.

PacifiCare® Asia Pacific

Policy and Procedure ***Division/Department:*** **Medical Management**

SUBJECT: Escalation of Requests to Medical Director

POLICY NO.: MM 09 **DATE ISSUED: 5-8-01** **PAGE 1 OF 1**

REVISION DATES:

AUTHORIZED BY: Mary Kleschen, MD, MPH, Medical Director **DATE: 5-8-01**

POLICY: Requests that need escalation to the Medical Director for questions, proposed denials, or for not meeting InterQual criteria will be given to the appropriate Authorization or Concurrent Review Nurse.

PURPOSE: The Authorization Nurses and Concurrent Review Nurses will be responsible for reviewing proposed denials, requests not meeting InterQual criteria, and other questions with the Medical Director on a daily basis.

PROCEDURE:

1.0 The Senior Authorization Coordinator will forward all requests to the Authorization Nurse when not meeting InterQual criteria. If there is no InterQual criteria available, market-based criteria will be used. If criteria is not met, the nurse will forward the request on a daily basis to the Medical Director.

2.0 The Authorization Nurses and Concurrent Review Nurses will meet on a daily basis with the Medical Director to review cases where criteria has not been met. All not meeting criteria and proposed denials will be reviewed.

3.0 The nurse may not override any InterQual or market-based criteria without the review and approval of the Medical Director.

PacifiCare•Asia Pacific

Policy and Procedure ***Division/Department:*** **Medical Management**

SUBJECT: Timely Turn-Around for Prior Authorization Requests

POLICY NO.: MM 10 **DATE ISSUED: 5-8-01** **PAGE 1 OF 2**

REVISION DATES:

AUTHORIZED BY: Mary Kleschen, MD, MPH, Medical Director **DATE: 5-8-01**

POLICY: Utilization decisions are made in a timely manner to accommodate the clinical urgency of the situation. Non-urgent requests will be processed within two (2) working days. Urgent requests will be processed within twenty-four (24) hours. Practitioners will be notified of the decision within one (1) working day. For requests that result in a denial, written notification of the decision will be sent within two (2) working days of making the decision to the member and the practitioner.

PURPOSE: Prior Authorization requests will be processed in a timely manner to facilitate providing medically necessary treatment for our members based on a the urgency of the situation.

PROCEDURE:

1.0 For prior authorization of non-urgent care, decisions will be made within two (2) working days of receiving the request.

2.0 For prior authorization of non-urgent care, notification to practitioners of the decision will be done within one (1) working day of making the decision via fax or telephone.

3.0 For prior authorization of non-urgent care that results in a denial, written confirmation of the decision will be sent within two (2) working days of make the decision via fax, mail or e-mail.

4.0 For prior authorization of urgent care, decision and notification to the practitioner will be made within one (1) calendar day. Notification will be by fax or telephone.

5.0 For prior authorization of urgent care that results in a denial, the member and practitioner will be notified how to initiate an expedited appeal at the time they are notified of the denial.

6.0 For prior authorization of urgent care that results in a denial, written and telephonic confirmation will be sent within two (2) working days of the date of decision.

7.0 Monthly logs will be maintained to measure turn-around time of requests. Results will be reviewed and reported on a monthly basis. Results will be monitored for non-compliance with policy.

Reference: Policy MM 07 (Denial of Services)

PacifiCare•Asia Pacific

Policy and Procedure ***Division/Department:*** **Medical Management**

SUBJECT: Concurrent Review Process

POLICY NO.: MM 11 **DATE ISSUED: 5-8-01** **PAGE 1 OF 2**

REVISION DATES:

AUTHORIZED BY: Mary Kleschen, MD, MPH, Medical Director **DATE: 5-8-01**

POLICY: Each member admitted to an acute care or skilled nursing facility will have their record reviewed for appropriateness of admission and continued stay. The reviewer and medical director in the review process will use criteria identified by the Medical Management plan. Reviews are usually conducted on a daily basis through discharge. Review may occur onsite or telephonically based upon whether the member is in an out-of-area or "off-island" facility.

PURPOSE: The purpose of this process is to ensure and track appropriate utilization and quality of the care being provided to our members in a consistent and timely manner.

PROCEDURE:

1.0 Concurrent Review Nurses (CRN) obtain facesheets or other admission information from facility. Psychiatric admissions are reviewed and tracked by contracted psychiatric/behavioral health provider.

2.0 All patients will have eligibility checked. If patient is a new enrollee who is not in the eligibility system or there are questions regarding eligibility, Membership Accounting will be contacted to confirm.

3.0 If member is not eligible, the CRN will notify the facility, the provider and the member.

4.0 The CRN or coordinator will assess for benefits limitations, exhaustion of benefits and/or coordination of benefits issues. If any benefits issues exist, the CNR or coordinator will notify the Claims department and the facility. If SNF admission, the CRN will verify the number of SNF days available.

5.0 The onsite CRN will review the member's records and apply InterQual criteria for all acute and SNF stays. The out-of-area/off-island CRN will request a verbal report or

faxed records from the out-of-area facility and then follow the procedure for InterQual as stated above. All reviews will be saved in reporting/tracking requirements.

6.0 The CRN or coordinator will enter the patient's admission and any applicable notes into the Facets system per Facets admission data entry protocol.

7.0 For off-island/out-of-area emergency or non-directed admissions, the CRN will contact the discharge planner and attending physician to assess for transition plan to in-network facility. The Claims department and Network Management department will be notified for coordination with out-of-network facility. All contacts will be documented in Facets system.

8.0 For members who do not meet criteria, the attending physician will be contacted for updated plan of care and/or change in level of care. If attending physician is unable to provide plan of care that meets criteria or refuses change in level of care, the case will be forwarded to the Medical Director for review. The Medical Director reviews case and makes determination on medical appropriateness. All communications and decisions will be documented in the Facets system.

9.0 Concurrent Review Nurses meet with the Medical Director formally on a weekly basis and daily as needed to review all inpatient stays for appropriateness and quality of care issues.

10.0 During the concurrent review process, potential quality issues may be identified. These will be communicated to the Quality Management department at PacifiCare Asia Pacific as well as the appropriate inpatient facility in order to improve patient outcomes.

11.0 The CRN will initiate discharge planning upon patient's admission and assist throughout the inpatient stay to facilitate a smooth transition at time of discharge. Upon admission, the CRNs will also begin review of benefits, i.e., SNF, Rehab, Home Health, DME with member and facility to facilitate to facilitate timely changes in level of care. The CRNs work closely with Home Health Care and Health Improvement departments for coordination of follow-up care and enrollment in disease management programs. The CRNs will also forward data to the QI department for CHF/AMI HEDIS and other ongoing tracking.

12.0 The CRNs will identify patients appropriate for case management and fill out a "Case Management Referral" form.

2003

GOVERNMENT OF GUAM/PACIFICARE ASIA PACIFIC

GROUP HEALTH INSURANCE AGREEMENT

ATTACHMENT I-A

PACIFICARE ASIA PACIFIC
MEDICAL RATES AND BENEFITS

OPTION A

0240

PCAP 0073

PACIFICARE ASIA PACIFIC
2003 MEDICAL MEMBERSHIP PREMIUMS

CLASS I EMPLOYEE OR RETIREE WITHOUT DEPENDENTS AND SURVIVORS OF RETIRED EMPLOYEES RECEIVING ANNUITY BENEFITS.

CLASS II EMPLOYEE OR RETIREE WITH ONE OR MORE DEPENDENTS.

CLASS III EMPLOYEE OR RETIREE WITH ONE OR MORE DEPENDENTS INCLUDING A SPOUSE WHO IS A GOVGUAM EMPLOYEE OR RETIREE ELIGIBLE UNDER THIS PLAN.

ACTIVES AND RETIREE/SURVIVORS COMBINED RATES

PREMIUMS FOR ACTIVES ARE PAYABLE OCTOBER 6, 2002 THROUGH OCTOBER 4, 2003

PREMIUMS FOR RETIREES ARE PAYABLE OCTOBER 1, 2002 THROUGH SEPTEMBER 30, 2003

ACTIVES RATES

	BI-WEEKLY TOTAL	MONTHLY TOTAL
CLASS I	$115.03	$249.24
CLASS II	$345.11	$747.73
CLASS III	$345.11	$747.73

RETIREES/SURVIVORS RATES

	BI-WEEKLY TOTAL	MONTHLY TOTAL
CLASS I	$124.62	$249.24
CLASS II	$373.87	$747.73
CLASS III	$373.87	$747.73

0241

PCAP 0074

MEDICAL BENEFITS

BENEFITS	Plan Coinsurance or Member Co-Pay
All benefits listed herein are covered based on Eligible Charges and are provided only for services considered Medically Necessary by PacifiCare unless otherwise specifically covered herein. The Member is responsible for any excess charges. Medical care, pharmacy services and hospital care rendered by non-participating Providers are not covered except with written prior authorization by the PacifiCare Medical Management Department or in cases of emergency.	
A. Hospital (Inpatient) Benefits will be paid for a maximum of 365 days of confinement during the Benefit Period. If Medically Necessary during said 365 days in accordance with an established treatment and discharge plan, the following benefits will be paid:	80% of Eligible Charges after $250 Co-pay per admission at the Guam Memorial Hospital or the Department of Mental Health and Substance Abuse. Additional Co-pay is not required if Member is readmitted for the same condition within 30 days.
1. Room & Board (semi private). Room and board including general nursing care at (I) 80% of Eligible Charges of the average semiprivate room rate or (ii) 80% of Eligible Charges of the daily average private room rate when deemed Medically Necessary. If a private room is Medically Necessary, as determined by the PacifiCare Medical Director, PacifiCare will pay the prevailing rate for the daily average private room rate. Any inpatient hospitalization needs prior authorization.	80% of Eligible Charges
2. Coverage for Intensive Care or Coronary Care unit which is equipped and operated according to generally recognized Hospital standards. Coverage is for a critical injury or illness provided that the Member is a Registered In-Patient and that the care rendered is appropriate.	80% of Eligible Charges
3. Laboratory Services.	80% of Eligible Charges

BENEFITS (Inpatient)	**Plan Coinsurance or Member Co-Pay**
4. X-ray Services. MRIs, CT scans, echocardiograms, ultrasounds and nuclear medicine	80% of Eligible Charges subject to benefit limitations
5. Skilled Nursing Facility. 80% of Eligible Charges for Registered In-Patient. To be eligible for this benefit, each of the following requirements must be met: (I) The facility must be approved by PacifiCare; (ii) The Member must be admitted upon the authorization of a physician and must be attended by a physician; and (iii) Confinement in the facility must not be primarily for comfort, convenience, rest cure or domiciliary care.	80% of Eligible Charges up to 60 days per Member per Benefit Period
6. Maternity Care.	80% of Eligible Charges $250 Co-pay per admission for services at the Guam Memorial Hospital
Birthing Center.	80% of Eligible Charges at Sagua Managu birthing center
Note: Inpatient non-spouse dependent care is not covered.	

BENEFITS (Inpatient)	**Plan Coinsurance or Member Co-pay**
7. Professional Medical Services. The medical benefits provided are visits to or by a physician for such medical services as the Member may require in the treatment of an injury or illness. Maternity care is also covered. PacifiCare will pay for the visit to or by a physician or mid-level practitioner for medical services as follows:	80% of Eligible Charges
(a) Hospital or Skilled Nursing Facility. 80% of Eligible Charges for each Hospital or Skilled Nursing Facility visit to a Member who is a Registered In-Patient.	60 Days Maximum for Skilled Nursing Facility
(b) Intensive Medical Care. 80% of Eligible Charges for intensive medical care visits for a critical injury or illness provided that the Member is a Registered In-Patient.	
(c) Consultation visit. 80% of Eligible Charges for consultation visits by a physician during Hospital confinement. To be eligible for payment hereunder, each of the following requirements must be met; (I) The attending physician must order the consultation; (ii) The Member must be confined as a Registered In Patient; and (iii) The consultation must be for reasons other than compliance with requirements imposed by the Hospital or Skilled Nursing Facility and (iv) the consultant's report must be included as a part of the patient's record kept by the Hospital or Skilled Nursing Facility.	
8. Prescribed drugs in accordance with the PacifiCare Formulary, unless a non-Formulary drug is Medically Necessary and prior authorized by PacifiCare.	80% of Eligible Charges

Note: Drugs prescribed while a Registered In-Patient does not include take-home drugs.

BENEFITS (Inpatient)	**Plan Coinsurance or Member Co-pay**
9. Operating Room, Endoscopic Room, Surgery and Supplies/Anesthesia & Supplies. Coverage is for charges for the operating and endoscopic rooms, surgical supplies, Hospital anesthesia services and supplies, drugs, and dressings. PacifiCare will pay 80% of the Eligible Charges for physician surgical services as the Member may require in the treatment of an injury or illness, which charge shall include such number of aftercare visits which are customarily provided by most physicians in connection with the particular surgical service performed and any charge for aftercare visits in excess of such number will not be paid for by PacifiCare. Except as provided in diagnostic lab and x-ray services, additional supplementary charges, if any, of a physician for supplies and equipment used for surgical services will not be paid for by PacifiCare. PacifiCare will pay 80% of Eligible Charges of either a private anesthesiologist or a hospital anesthesiologist when the services of an anesthesiologist are required. If the hospital charges for its ancillary services on an all-inclusive daily rate basis, PacifiCare shall pay a daily allowance for such ancillary services in lieu of its payment of the Eligible Charges, which allowance shall be in an amount equal to 80% of the Eligible Charges for such ancillary services, but in no event more than PacifiCare would have paid if the hospital had separately charged for such services.	80% of Eligible Charges

BENEFITS (Inpatient)	**Plan Coinsurance or Member Co-pay**
10. Mental Health Care. Coverage is for all treatment and services recommended by a Participating Provider and contained in a treatment plan. The treatment plan may include services, drugs and supplies described elsewhere in this Schedule of Benefits. PacifiCare will cover the services only when PacifiCare determines that the care is Medically Necessary to treat the Member's condition, and only if the Member receives the care as part of a treatment and discharge plan developed by a Participating Provider. Note: The Participating Provider will develop a treatment plan to assist the Member in improving or maintaining his or her condition and functional level, or to prevent relapse. • Inpatient psychiatric care • Hospital alternative services, such as partial hospitalization, day treatment, and intensive outpatient psychiatric treatment programs Note: All inpatient admissions, hospital alternative services, and day treatment programs require prior authorization from PacifiCare. Alternative care settings have a 30 consecutive day benefit maximum per Member per Benefit Period.	80% of Eligible Charges after a $250 Co-pay per admission at the Department of Mental Health and Substance Abuse
11. Rehabilitation Facility.	80% of Eligible Charges up to 30 consecutive days per Member per Benefit Period

BENEFITS (Outpatient)	Plan Coinsurance or Member Co-pay
B. Out Patient In-area services must be provided by Participating Providers.	
1. In Area Emergency Services. The PacifiCare customer Service Department must be notified within 48 hours, or as soon as is reasonably possible, not to exceed 72 hours, if medically possible. PacifiCare will not pay for non-Emergency use of the hospital's Emergency facilities.	80% of Eligible Charges
2. Outpatient services provided at an Outpatient Facility	80% of Eligible Charges
3. Urgent Care at the PacifiCare Health Center only.	$5.00 Co-pay per office visit during normal business hours; $25.00 Co-pay per office visit after 5 p.m., weekends and holidays
4. Diagnostic Lab. Charges for diagnostic laboratory services	100% of Eligible Charges
5. Diagnostic X-ray	
(a) X-ray (plain film) and mammograms	(a) $5.00 Co-pay per visit
(b) MRIs, CT scans, ultrasounds, echocardiograms Prior authorization required for MRI and CT scans	(b) 80% of Eligible Charges

BENEFITS (Outpatient)	**Plan Coinsurance or Member Co-pay**
6. Physician Service. The medical benefits provided are visits to or by a physician or other medical provider for such medical services as the Member may require in the treatment of an injury or illness.	$5.00 Co-pay per office visit for Primary Care $25.00 Co-pay per office visit for Specialty Care.
7. Maternity Care. Note: Non-spouse dependent outpatient maternity care is limited to $500. No benefit shall be paid for inpatient hospital services.	$5.00 Co-pay per office visit.
8. Mental Health Care. Outpatient mental health services are a benefit when rendered by the following providers only: (i) Government of Guam Department of Mental Health and Substance Abuse Agency; (ii) psychiatrist, defined as a medical doctor who has specialty in psychiatry; (iii) psychologist, defined as an individual who has a Ph.D. in clinical or counseling psychology, (iv) Individual, Marriage and Family Counselors, who are licensed mental health counselors on Guam and who possess at least a masters degree with a clinical practicum plus two years of supervised clinical experience. Course work for the masters degree must include courses in: marriage and family therapy, psychopathology, human sexuality, and clinical practicum. Services rendered by individuals not meeting the above qualifications shall not be covered. Mental health care may only be accessed by a referral from the Member's Primary Care Physician and the participating mental health provider must provide a treatment plan for the provision of care to the Member.	$25.00 Co-pay per office visit
9. Annual Eye Exam. Coverage for routine screening eye examinations.	$5.00 Co-pay per office visit. $50.00 benefit maximum per Member per Benefit Period
10. Immunizations.	100% of Eligible charges per visit

BENEFITS (Outpatient)	**Plan Coinsurance or Member Co-pay**
11. Physical Exam, Annual. Coverage for physician fees, laboratory and diagnostic studies. Mammograms are provided in accordance with 4GCA, 4301 (e).	$5.00 Co-pay per office visit. $200.00 benefit limitation per Member per Benefit Period
12. Well-Child-Care. Coverage for physician fees, laboratory and diagnostic studies included in up to five (5) well-child visits per Benefit Period for children under two (2) years of age.	$5.00 Co-pay per office visit
13. Health Education. Coverage for classes provided by the PacifiCare Health Center only.	80% of Eligible Charges
14. Prescription Drugs. Coverage for the original prescription and refill prescription. PacifiCare will pay for only normal and reasonable quantities of a prescription drug, and such quantity shall not in any event exceed an amount, which under normal use will last for more than 30 days. Prescription drugs are generally limited to those within the PacifiCare Formulary. Non-Formulary prescriptions are covered when Medically Necessary and prior authorized by PacifiCare.	$10 Co-pay for Generic drugs and $20 Co-pay for Brand drugs, per Prescription Drug Unit. Mail-order program: No Co-pay for Generic and Brand Formulary for 90-day supply. $20 Co-pay for non-Formulary per Prescription Drug Unit.
15. Injectable prescription drugs. Coverage for injectable drugs administered at home or in the physician's office.	80% of Eligible Charges; waived if administered through PacifiCare Home Health
16. Birth Control Pills.	Subject to the Prescription Drugs benefit
17. Contraceptive Devices limited to intrauterine devices (IUDs) and diaphragms.	80% of Eligible Charges

Plan Coinsurance or Member Co-Pay

Benefits (Outpatient)

18. Physical Therapy. Includes neuromuscular rehabilitation, provided by a covered physical therapist acting within the scope of his or her license subject to the condition that all visits in excess of 20 visits shall be paid at 50% of the Eligible Charges. For physical therapy, only services provided by a registered physical therapist (RPT), or services provided by a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) are recognized for coverage. Physical therapy will be considered necessary when provided to restore a bodily function that once existed and has been lost or damaged due to disease or accidental injury. Such therapy is covered only to the extent that it restores function to the status pre-existing disease or accidental injury. Therapy must result in significant and demonstrable improvement in the Member's ability to function independently. Cognitive function, although dependent on the function of the brain, is not considered a bodily function for purposes of this benefit.	$25.00 Co-pay per visit for 20 visits per Member per Benefit Period. PacifiCare will pay 50% of Eligible Charges thereafter

	BENEFITS (Outpatient)	**Plan Coinsurance or Member Co-pay**
	19. Elective Surgery. (Prior authorization required. The surgery must be Medically Necessary.) PacifiCare will not pay for charges incurred for use of the hospital's outpatient facilities, supplies and equipment in connection with elective minor surgical services or medical services that could be received in a Physician's office or at a plan-contracted surgi-center.	80% of Eligible Charges when prior authorized by PacifiCare
C.	Out-Of-Area Emergency and Referral Services.	80% of Eligible Charges of 1st $5,000, 100% of Eligible Charges of balance up to $100,000 per Benefit Period.
D.	Allergy Testing & Treatment. Charges in connection with allergy testing and treatment. Coverage is limited to allergy serum, allergy injections, testing and treatment.	$25.00 Co-pay per office visit. $500 benefit limitation per Member per Benefit Period
E.	Ambulance Service (Medically Necessary and ground transportation only)	80% of Eligible Charges
F.	Cardiac Surgery.	80% of Eligible Charges up to $50,000 benefit limitation per Member per Benefit Period

	BENEFITS	**Plan Coinsurance or Member Co-pay**
G.	Congenital Abnormality and Complications of the Neonatal Period.	80% of Eligible Charges
H.	Accidental Injury to the Mouth. Palliative (emergency) care provided by a dentist or physician is covered to alleviate pain and other acute symptoms resulting from the injury. Such may include debridement of wounds, suturing, extraction of broken teeth, splinting of loose teeth, wiring of jaws, smoothing jagged edges of broken teeth. Specifically excluded are fillings, crowns, bridges, dentures, bonding and similar permanent restorations.	80% of Eligible Charges.
I.	Home Health Care. Home health care ordered by a Participating Provider rendered by a licensed practitioner or a home health aide. Services include IV therapy and medications. Services ordered by a physician to homebound Members: • Nursing • Physical therapy, respiratory therapy • Medical supplies included in the home health plan of care Note: IV therapy and medications are covered under the prescription drug benefit.	100% of Eligible Charges when provided or authorized by PacifiCare Home Health
J.	Interrupted Pregnancy.	Covered 80% of Eligible Charges when Medically Necessary and in accordance with the law
K.	Plan Maximum Coverage.	$1,000,000 per Member per lifetime

BENEFITS	**Plan Coinsurance or Member Co-pay**
L. Durable Medical Equipment. As prescribed by a doctor 1. Wheelchair 2. Hospital bed/commode 3. Oxygen & accessories a. Oxygen concentrator b. Oxygen masks, c. Nasal canula tubing d. One filled oxygen tank (not to exceed 22 cu. ft.), no refills 4. Suction machine 5. Crutches/Walkers 6. Masks	80% of Eligible Charges for the rental or purchase (at PacifiCare's option) of the durable medical equipment when Medically Necessary and authorized by PacifiCare using current criteria set up by Medicare
M. Nuclear Medicine -prior authorization required	80% of Eligible Charges per visit. $25,000 benefit limitation per Member per Benefit Period

	BENEFITS	**Plan Coinsurance or Member Co-pay**
N.	Radiation Therapy. Limitation applies to therapy provided externally or by internally implanted devices.	80% of Eligible Charges per visit. $25,000 benefit limitation per Member per Benefit Period
O.	Sterilization Procedure.	
	1. Tubal Ligation – outpatient services only unless performed in conjunction with delivery	$25.00 Co-pay
	2. Vasectomy – outpatient services only	$25.00 Co-pay
P.	Eligible off-island Dependent Students -when eligibility requirements are met	Covered for Out-of-Area Emergency and Referral Services as stated in section C above.
Q.	If an appropriate service is available on Guam, PacifiCare must provide that service on Guam if the service meets industry standards of care acceptable to PacifiCare. PacifiCare's Medical Director will determine the appropriateness of an available service and/or medical facility based on accepted industry standards.	80% of Eligible Charges

	BENEFITS	Plan Coinsurance or Member Co-pay
R.	Chronic orthopedic conditions including internal prosthetic devices and external prosthetic devices. Except as specifically excluded under this Agreement, services, supplies and devices related to the treatment of chronic orthopedic conditions are covered. This includes: i. internal and external prosthetic devices including artificial joints, limbs and spinal segments ii. orthotic devices, which are defined as appliances, or apparatus that support or align movable parts of the body, correct deformities or improve the functioning of movable parts of the body not available for purchase as an over-the-counter product. iii. treatment of joint conditions including arthritis iv. treatment of bone conditions including osteoarthritis, osteoporosis, osteosclerosis, spina bifida, bone cell tumors and fractures v. treatment of ligament and cartilage conditions	80% of Eligible Charges up to $50,000 benefit limitation per Member per Benefit Period.
S.	Blood and blood products/derivatives and their administration.	80% of Eligible Charges up to $50,000 benefit limitation per Member per Benefit Period for blood and blood products. Costs incurred for their administration shall not accumulate toward this maximum.

	BENEFITS	Plan Coinsurance or Member Co-pay
T.	Hearing aids. Testing for hearing aids is not covered.	$500 benefit limitation per Member per Benefit Period
U.	Chiropractic Care.	20 visit maximum per Member per Benefit Period. Plan pays $25 maximum per visit
V.	Hospice Care. Member must be expected to die within 6 months and shall not be entitled to any care for the terminal illness except for palliative care. Care must be provided on Guam through a bonafide hospice program.	Maximum of 180 days and one hospice confinement per Member per lifetime. Plan pays $50 maximum per day
W.	Chemical Dependency. Coverage is for all treatment services recommended by a Participating Provider and contained in a treatment plan. The treatment plan may include services, drugs and supplies described elsewhere in this Schedule of Benefits. PacifiCare will cover the services only when PacifiCare determines that the care is Medically Necessary to treat the Member's condition, and only if the Member receives the care as part of a treatment and discharge plan developed by a Participating Provider.	Inpatient services are covered 80% after a $250 Co-pay per admission. Outpatient services are covered with a $25.00 Co-pay per office visit.
	Diagnosis and treatment of alcoholism and drug abuse. Outpatient services include: • Detoxification (the withdrawal process from physically-addictive drugs and/or alcohol when withdrawal is likely to cause medical or life-threatening complications) • Treatment and counseling (including individual and group therapy visits) Note: The Participating Provider will develop a treatment plan to assist the Member in improving or maintaining his or her condition and functional level, or to prevent relapse. • Inpatient substance abuse care • Day treatment programs for substance abuse Note: All inpatient admissions, hospital alternative services, and day treatment programs require approval from PacifiCare. Alternative care settings have a 30- day benefit maximum per Member per Benefit Period.	A maximum of $8,000 per Member per year and $16,000 per Member per life time shall apply to chemical dependency treatments

BENEFITS

		Plan Coinsurance or Member Co-Pay
X.	Breast Reconstruction. All stages of the breast reconstruction surgery following a mastectomy including reconstruction of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of all states of mastectomy, including lymphedemas, are covered. Such reconstruction procedures are not limited to reconstructive procedures necessitated by a mastectomy performed while covered under this plan.	80% of Eligible Charges
Y.	Acupuncture	10 visit maximum per Member per Benefit Period. Plan pays maximum of $50 per visit
Z.	Podiatry Services Foot care only when you are under active treatment for: • Metabolic disease such as diabetes, or • Peripheral vascular disease	$25.00 Co-pay per office visit
AA.	Hyperbaric Oxygen (HBO) Treatment -prior authorization required	80% of Eligible Charges
AB.	In Service Area Out-of-Pocket Maximum: The maximum total out-of-pocket costs, including all Deductibles, Co-payments and Coinsurance that a Member can be held liable for during a Benefit Period for expenses incurred within the Service Area before PacifiCare begins paying 100% of covered benefits. Following are Member expenses which will not accumulate towards the In-Service Area Out-of-Pocket Maximum: (a) expenses in excess of Plan maximums, (b) expenses for non-covered services, (c) expenses incurred Out-of-Service Area, and (d) expenses incurred through non-Participating Providers.	Individual – $2,000 Family - $6,000

BENEFITS		Plan Coinsurance or Member Co-Pay
AC.	Out-of-Service Area Out-of-Pocket Maximum: The maximum total out-of-pocket costs, including all Co-payments and Coinsurance and Deductible that a Member can be held liable for during a Benefit Period for expenses incurred outside the Service Area before PacifiCare begins paying 100% of covered benefits.	The lesser of $1000 or 20% of the first $5,000.

EXCLUSIONS

1. No benefits will be paid for injury or illness, (a) when the Member is entitled to receive disability benefits or compensation (or forfeits his or her right thereto) under Worker's Compensation or Employer's Liability Law for such injury or illness or (b) when services for an injury or illness are rendered to the Member by any federal, state, territorial, municipal or other governmental instrumentality or agency without charge, or (c) when such services would have been rendered without charge but for the fact that the person is an Member under the Plan

2. No benefits will be paid if any material statement made in an application for coverage, in enrollment of any dependent or in any claim for benefits is false. Upon identifying any such false statement, Company shall notify the Member that his or her benefits have been suspended and that his or her coverage shall be terminated retroactive to the date of suspension unless the Member files a claim under the grievance procedure provided for in the agreement. If a grievance is filed, the resolution of the matter shall be in accordance with the outcome of the grievance proceedings. If no grievance is filed, and Company paid benefits, prior to learning of any such false statement, the subscriber must reimburse the Company for such payment

3. No benefits will be paid for confinement in a hospital or in a skilled nursing facility if such confinement is primarily for custodial or domiciliary care (Custodial or domiciliary care includes that care which consists of training in personal hygiene, routine nursing services and other forms of self-care. Custodial or domiciliary care also includes supervisory services by a physician or nurse for a person who is not under specific medical or surgical treatment to reduce his or her disability and to enable that person to live outside an institution providing such care)

4. No benefits will be paid for services and supplies and drugs not specifically described as covered in the Agreement

5. No benefits will be paid for services and supplies and drugs provided to an Member for and injury or illness resulting from an attempted suicide by that Member unless resulting from a medical condition (including physical or mental conditions) or from domestic violence

6. No benefits will be paid for services and supplies and drugs provided to an Member for injuries incurred while that Member was committing a criminal act

7. Unless otherwise specifically provided in the agreement, no benefit will be paid for or in connection with airfare and the Company will not pay for the transportation from Guam to any off-island facility, nor for any other non-medical expenses such as taxes, taxis, hotel rooms, etc. In no event will the Company pay for air ambulance or for the transportation of the remains of any deceased person

EXCLUSIONS

8. No benefit will be paid for living expenses for insureds who require, or who of their own accord seek, treatment in locations removed from their home

9. No benefit will be paid for services and supplies and drugs provided to a dependent of a non-spouse dependent. Dependents of non-spouse dependents are not eligible for coverage. For example, when a dependent, other than a spouse of the subscriber, has a child, that child is a dependent of a non-spouse dependent and is not eligible to become covered under the Plan, unless such child otherwise becomes eligible for enrollment

10. No benefit will be paid for services furnished by immediate relatives or members of the Member's household unless service rendered by such persons are rendered as employees of a hospital, physician, or other provider

11. No benefit will be paid for services and supplies and drugs provided for occupational and/or speech therapy regardless of the condition for which such services and supplies and drugs are provided

12. No benefit will be paid for charges made by a provider for services provided through telephone conferences or interviews during which the Member is not seen for treatment

13. No benefit will be paid for:

    a) drugs or substances not approved by the Food and Drug Administration (FDA); or

    b) drugs or substances not approved by the FDA for treatment of the illness or injury being treated unless empirical clinical studies have proven the benefits of such drug or substance in treating the illness or injury; or

    c) drugs or substances labeled "Caution: limited by federal law to investigational use"

14. No benefit will be paid in connection with or for experimental procedures not approved by payment by Medicare

15. No benefit will be paid for any item or substances that is available without a physician's prescription even if prescribed by a physician, except as otherwise provided herein and except for medicines and supplies Medically Necessary for inpatient care

EXCLUSIONS

16. No benefits will be paid for services and supplies and drugs provided to perform transsexual surgery or to evaluate the need for such surgery. Evaluations and subsequent medications and services necessary to maintain transsexual status are also excluded from coverage, as are complications or medical sequelae of such surgery or treatment

17. No benefit will be paid for injuries incurred while operating a motorized vehicle while under the influence of intoxicating alcoholic beverage, controlled drugs, or substances. If a blood alcohol level or the DRAEGER ALCO TEST is available and shows levels that are equal to or exceed 0.08 grams percent (gms%) or that exceed the amount allowed by law as constituting legal intoxication, no benefits will be paid

18. No benefit will be paid for services and supplies and drugs provided for visual training, including the provision of special prism lenses

19. No benefit will be paid for medical service or supply which is available to the Member on Guam and which is paid by or reimbursable through a governmental agency or institution. However, notwithstanding the aforesaid, in no event will the company consider the availability of benefits under Medicaid or the Medically Indigent Program when paying benefits under this Agreement

20. No benefits will be paid for audiograms, regardless of the reason for such tests

21. No benefit will be paid for services and supplies and drugs for the treatment or diagnosis of temporomandibular joint (TMJ) disorders. This includes, but is not limited to:
    a) services of a Dentist;
    b) bite plates;
    c) braces to straighten the teeth;
    d) orthognathic surgery to correct a bite defect;
    e) surgical procedures in direct treatment of TMJ, including surgery on the joint itself or on the Hyold bone;
    f) arthrogram or other X-ray of the TMJ, and also including magnetic reasonance imaging
    g) biofeedback or the insertion of TENS units or related devices

EXCLUSIONS

22. No benefit will be paid for services and supplies and drugs provided for the purpose of organ transPlantation. All organ transPlants are excluded from coverage, including but not limited to: heart, lung, liver, kidney, pancreas, bone marrow and comea. Autologous bone marrow transPlant (where the donor is also the recipient) is also excluded. Services and supplies and drugs directly related to the transPlant, such as tissue typing and other pre-operative procedures are excluded as are services and supplies and drugs provided post-operatively which are a consequence of the transPlant surgery or the presence of the transPlanted organ. This exclusion for post-operative supplies and services continues for the life of the patient. Benefits directly related to the transPlant will cease as of the time when it is determine that a transPlant will be performed

23. No benefits will be paid for services and supplies and drugs provided in the course of organ donation whether for an Member who is donating an organ or for someone who is donating an organ for transPlantation into an Member

24. Except as otherwise provided in the agreement, no benefit will be paid in connection with dental care or for any treatment to the teeth, jaws and dependent tissues ordinarily performed by a dentist

25. No benefit will be paid in connection with elective abortions unless Medically Necessary

26. No benefit will be paid for eyeglasses or contact lenses or for services and supplies and drugs in connection with surgery for the purpose of diagnosing or correcting errors in refraction

27. No benefit will be paid for examinations related to the prescription or fitting of a hearing aid

28. No benefit will be paid in connection with any injuries sustained while the Member is operating any wheeled vehicle during an organized, off-road, competitive sporting event

29. No benefit will be paid in connection with personal comfort items such as, but not limited to, telephone, television, and guest trays

30. No benefit will be paid in connection with dialysis treatments which would have been charged in the absence of the Plan

31. No benefits will be paid for services and supplies and drugs provided for the treatment of/for mental retardation or mental deficiency

EXCLUSIONS

32. No benefits will be paid for services and supplies and drugs provided for cosmetic surgery or treatment, even for psychological reasons, unless:
    a.) The need for surgery or treatment is caused by a non-occupational trauma or by a surgery which occurred while the Member was covered under the Plan, and
    b.) The surgery or treatment is performed for the purpose of reconstruction and also restores bodily function which has been lost or damaged; or
    c.) The surgery or treatment is required pursuant to the Women's Health and Cancer Rights Act of 1998. Accordingly, reconstruction of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of all states of mastectomy, including lymphedemas, are covered. Such reconstruction procedures are not limited to reconstruction procedures necessitated by a mastectomy performed while covered under the Plan

33. No benefit will be paid for services and supplies and drugs associated with growth hormone treatment unless the Member is proven to have growth hormone deficiency using accepted stimulate growth hormone analyses and also shows an accelerated growth response to growth hormone treatment. Under no circumstances will growth hormone treatment be covered to treat short stature in the absence of proven growth hormone deficiency

34. No benefits will be paid for services and supplies and drugs provided for liposuction

35. No benefit will be paid for any drug, food substitute or supplement or any other product which is primarily for weight control even if it prescribed by a physician

36. If for the purpose of weight reduction or aesthetic purposes, no benefit will be paid in connection with gastric bypass, stapling or reversal

37. No benefit will be paid for services and supplies and drugs provided for the diagnosis and/or treatment of infertility. Services and supplies and drugs include, but are not limited to, in-patient and out-patient services for pharmaceuticals, physician services, surgeries, and counseling

38. No benefit will be paid for services and supplies and drugs provided for the conception by artificial means including, but no limited to artificial insemination, invitro fertilization and embryo transfer

39. No benefit will be paid for services an supplies and drugs provided for the reversal of a voluntary sterilization

EXCLUSIONS

40. No benefit will be paid for services and supplies and drugs provided for actual or attempted artificial impregnation or fertilization

41. No benefits will be paid for the purchase or rental of durable or disposable medical equipment and supplies, other than for equipment and supplies used in a hospital or skilled nursing facility or in conjunction with an approved hospital or skilled nursing facility confinement or as otherwise noted in the Agreement

42. No benefit will be paid for services and supplies and drugs provided for penile implants of any type

43. Except for intraoccular lens implants, pace makers, heart valves, cardiac stents and as provided herein, no benefit will be paid in connection with any implants or transplants

44. No benefits will be paid for services and supplies and drugs to correct sexual dysfunction

45. No benefit will be paid for services and supplies and drugs provided in connection with intentionally self-induced or intentionally self inflected injuries or illnesses unless resulting from a medical condition (including physical or mental conditions) or from domestic violence

46. Except as specifically provided, if a benefit is excluded, all hospital, surgical, medical treatments, prescription drugs, laboratory services, and x-rays in relation to the excluded benefit are also excluded as of the time it is determined that the excluded benefit will be provided

47. Non-emergency ground ambulance services

48. Elective or voluntary enhancement procedures, surgeries, services, supplies and medications including, but not limited to hair growth, hair removal, sexual performance, athletic performance, anti-aging, and mental performance, even if prescribed by a physician

49. Hospital take home drugs

50. Fees for any missed appointments or voluntary transfer of records as requested by the Member

EXCLUSIONS

51. Intelligence, IQ, aptitude ability, learning disorders, or interest tasting not necessary to determine the appropriate treatment of a psychiatric condition

52. Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of a diagnosis or symptoms or whether providing or receiving the service

53. Except as specifically provided in this Agreement, services and supplies not ordered by a physician or not Medically Necessary

54. Except as specifically provided in this Agreement, no benefit will be provided for the treatment of orthopedic conditions, prosthetic devices or any services related thereto, including:

    a. External devices. Non-orthopedic external prosthetic devices, disposable prosthetic devices, non-orthopedic corrective appliance and prosthetic and orthotic devices and supplies available over-the-counter
    b. Internal devices. Non-orthopedic internal prosthetic devices, except pace makers, heart valves, intra ocular lenses and stents
    c. Orthopedic footwear. Orthopedic footwear unless attached to an artificial foot or unless attached as a permanent part of a leg brace
    d. Motorized limbs. Motorized artificial limbs
    e. TMJ. Treatment of temporomandibular joint diseases
    f. Durable medical equipment. Durable medical equipment, unless specifically covered in this Agreement

55. Except as specifically provided in this Agreement, corrective appliances, artificial aids and durable equipment, including inhalation therapy related equipment

56. Services for which an Member or Subscriber is not legally obligated to pay

57. Except as specifically provided in this Agreement, services or supplies provided or prescribed by a chiropractor or acupuncturist

2003

GOVERNMENT OF GUAM/PACIFICARE ASIA PACIFIC

GROUP HEALTH INSURANCE AGREEMENT

ATTACHMENT I-A

PACIFICARE ASIA PACIFIC MEDICAL RATES AND BENEFITS

OPTION B

PACIFICARE ASIA PACIFIC
2003 MEDICAL MEMBERSHIP PREMIUMS

CLASS I OF EMPLOYEE OR RETIREE WITHOUT DEPENDENTS AND SURVIVORS RETIRED EMPLOYEES RECEIVING ANNUITY BENEFITS.

CLASS II EMPLOYEE OR RETIREE WITH ONE OR MORE DEPENDENTS.

CLASS III EMPLOYEE OR RETIREE WITH ONE OR MORE DEPENDENTS INCLUDING A SPOUSE WHO IS A GOVGUAM EMPLOYEE OR RETIREE ELIGIBLE UNDER THIS PLAN.

ACTIVES AND RETIREE/SURVIVORS COMBINED RATES

PREMIUMS FOR ACTIVES ARE PAYABLE OCTOBER 6, 2002 THROUGH OCTOBER 4, 2003

PREMIUMS FOR RETIREES ARE PAYABLE OCTOBER 1, 2002 THROUGH SEPTEMBER 30, 2003

ACTIVES RATES

	BI-WEEKLY TOTAL	MONTHLY TOTAL
CLASS I	$64.08	$138.85
CLASS II	$192.25	$416.55
CLASS III	$192.25	$416.55

RETIREES/SURVIVORS RATES

	BI-WEEKLY TOTAL	MONTHLY TOTAL
CLASS I	$69.43	$138.85
CLASS II	$208.28	$416.55
CLASS III	$208.22	$416.55

MEDICAL BENEFITS

BENEFITS	Plan Coinsurance or Member Co-Pay
All benefits listed herein are covered based on Eligible Charges and are provided only for services considered Medically Necessary by PacifiCare unless otherwise specifically covered herein. The Member is responsible for any excess charges. Medical care, pharmacy services and hospital care rendered by non-participating Providers are not covered except with written prior authorization by the PacifiCare Medical Management Department or in cases of emergency.	
A. Hospital (Inpatient) Benefits will be paid for a maximum of 365 days of confinement during the Benefit Period. If Medically Necessary during said 365 days in accordance with an established treatment and discharge plan, the following benefits will be paid:	80% of Eligible Charges after $250 Co-pay per admission at the Guam Memorial Hospital or the Department of Mental Health and Substance Abuse. Additional Co-pay is not required if Member is readmitted for the same condition within 30 days.
1. Room & Board (semi private). Room and board including general nursing care at (i) 80% of Eligible Charges of the average semiprivate room rate or (ii) 80% of Eligible Charges of the daily average private room rate when deemed Medically Necessary. If a private room is Medically Necessary, as determined by the PacifiCare Medical Director, PacifiCare will pay the prevailing rate for the daily average private room rate. Any inpatient hospitalization needs prior authorization.	
2. Coverage for Intensive Care or Coronary Care unit which is equipped and operated according to generally recognized Hospital standards. Coverage is for a critical injury or illness provided that the Member is a Registered In-Patient and that the care rendered is appropriate.	80% of Eligible Charges
3. Laboratory Services.	80% of Eligible Charges

BENEFITS (Inpatient)	**Plan Coinsurance or Member Co-Pay**
4. X-ray Services. MRIs, CT scans, echocardiograms, ultrasounds and nuclear medicine	80% of Eligible Charges subject to benefit limitations
5. Skilled Nursing Facility. 80% of Eligible Charges for Registered In-Patient. To be eligible for this benefit, each of the following requirements must be met: (I) The facility must be approved by PacifiCare; (ii) The Member must be admitted upon the authorization of a physician and must be attended by a physician; and (iii) Confinement in the facility must not be primarily for comfort, convenience, rest cure or domiciliary care.	80% of Eligible Charges up to 60 days per Member per Benefit Period
6. Maternity Care.	80% of Eligible Charges $250 Co-pay per admission for services at the Guam Memorial Hospital
Birthing Center.	80% of Eligible Charges at Sagua Managu birthing center

Note: Inpatient non-spouse dependent care is not covered.

BENEFITS (Inpatient)	**Plan Coinsurance or Member Co-pay**
7. Professional Medical Services. The medical benefits provided are visits to or by a physician for such medical services as the Member may require in the treatment of an injury or illness. Maternity care is also covered. PacifiCare will pay for the visit to or by a physician or mid-level practitioner for medical services as follows:	80% of Eligible Charges
(a) Hospital or Skilled Nursing Facility. 80% of Eligible Charges for each Hospital or Skilled Nursing Facility visit to a Member who is a Registered In-Patient.	60 Days Maximum for Skilled Nursing Facility
(b) Intensive Medical Care. 80% of Eligible Charges for intensive medical care visits for a critical injury or illness provided that the Member is a Registered In-Patient.	
(c) Consultation visit. 80% of Eligible Charges for consultation visits by a physician during Hospital confinement. To be eligible for payment hereunder, each of the following requirements must be met; (I) The attending physician must order the consultation; (ii) The Member must be confined as a Registered In Patient; and (iii) The consultation must be for reasons other than compliance with requirements imposed by the Hospital or Skilled Nursing Facility and (iv) the consultant's report must be included as a part of the patient's record kept by the Hospital or Skilled Nursing Facility.	
8. Prescribed drugs in accordance with the PacifiCare Formulary, unless a non-Formulary drug is Medically Necessary and prior authorized by PacifiCare	80% of Eligible Charges

Note: Drugs prescribed while a Registered In-Patient does not include take-home drugs.

BENEFITS (Inpatient)	**Plan Coinsurance or Member Co-pay**
9. Operating Room, Endoscopic Room, Surgery and Supplies/Anesthesia & Supplies. Coverage is for charges for the operating and endoscopic rooms, surgical supplies, Hospital anesthesia services and supplies, drugs, and dressings. PacifiCare will pay 80% of the Eligible Charges for physician surgical services as the Member may require in the treatment of an injury or illness, which charge shall include such number of aftercare visits which are customarily provided by most physicians in connection with the particular surgical service performed and any charge for aftercare visits in excess of such number will not be paid for by PacifiCare. Except as provided in diagnostic lab and x-ray services, additional supplementary charges, if any, of a physician for supplies and equipment used for surgical services will not be paid for by PacifiCare. PacifiCare will pay 80% of Eligible Charges of either a private anesthesiologist or a hospital anesthesiologist when the services of an anesthesiologist are required. If the hospital charges for its ancillary services on an all-inclusive daily rate basis, PacifiCare shall pay a daily allowance for such ancillary services in lieu of its payment of the Eligible Charges, which allowance shall be in an amount equal to 80% of the Eligible Charges for such ancillary services, but in no event more than PacifiCare would have paid if the hospital had separately charged for such services.	80% of Eligible Charges

BENEFITS (Inpatient)	**Plan Coinsurance or Member Co-pay**
10. Mental Health Care. Coverage is for all treatment and services recommended by a Participating Provider and contained in a treatment plan. The treatment plan may include services, drugs and supplies described elsewhere in this Schedule of Benefits. PacifiCare will cover the services only when PacifiCare determines that the care is Medically Necessary to treat the Member's condition, and only if the Member receives the care as part of a treatment and discharge plan developed by a Participating Provider. Note: The Participating Provider will develop a treatment plan to assist the Member in improving or maintaining his or her condition and functional level, or to prevent relapse. • Inpatient psychiatric care • Hospital alternative services, such as partial hospitalization, day treatment, and intensive outpatient psychiatric treatment programs Note: All inpatient admissions, hospital alternative services, and day treatment programs require prior authorization from PacifiCare. Alternative care settings have a 30 consecutive day benefit maximum per Member per Benefit Period.	80% of Eligible Charges after a $250 Co-pay per admission at the Department of Mental Health and Substance Abuse
11. Rehabilitation Facility.	80% of Eligible Charges up to 30 consecutive days per Member per Benefit Period

BENEFITS (Outpatient)	**Plan Coinsurance or Member Co-pay**
B. Out Patient In-area services must be provided by Participating Providers.	
1. In Area Emergency Services. The PacifiCare customer Service Department must be notified within 48 hours, or as soon as is reasonably possible, not to exceed 72 hours, if medically possible. PacifiCare will not pay for non-Emergency use of the hospital's Emergency facilities.	80% of Eligible Charges
2. Outpatient services provided at an Outpatient Facility	80% of Eligible Charges
3. Urgent Care at the PacifiCare Health Center only.	$10.00 Co-pay per office visit during normal business hours; $25.00 Co-pay per office visit after 5 p.m., weekends and holidays
4. Diagnostic Lab. Charges for diagnostic laboratory services	100% of Eligible Charges
5. Diagnostic X-ray	
(a) X-ray (plain film) and mammograms	(a) $10.00 Co-pay per visit
(b) MRIs, CT scans, ultrasounds, echocardiograms Prior authorization required for MRI and CT scans	(b) 80% of Eligible Charges

BENEFITS (Outpatient)	**Plan Coinsurance or Member Co-pay**
6. Physician Service. The medical benefits provided are visits to or by a physician or other medical provider for such medical services as the Member may require in the treatment of an injury or illness.	$10.00 Co-pay per office visit for Primary Care $25.00 Co-pay per office visit for Specialty Care.
7. Maternity Care. Note: Non-spouse dependent outpatient maternity care is limited to $500. No benefit shall be paid for inpatient hospital services.	$25.00 Co-pay per office visit.
8. Mental Health Care. Outpatient mental health services are a benefit when rendered by the following providers only: (i) Government of Guam Department of Mental Health and Substance Abuse Agency; (ii) psychiatrist, defined as a medical doctor who has specialty in psychiatry; (iii) psychologist, defined as an individual who has a Ph.D. in clinical or counseling psychology, (iv) Individual, Marriage and Family Counselors, who are licensed mental health counselors on Guam and who possess at least a masters degree with a clinical practicum plus two years of supervised clinical experience. Course work for the masters degree must include courses in: marriage and family therapy, psychopathology, human sexuality, and clinical practicum. Services rendered by individuals not meeting the above qualifications shall not be covered. Mental health care may only be accessed by a referral from the Member's Primary Care Physician and the participating mental health provider must provide a treatment plan for the provision of care to the Member.	$25.00 Co-pay per office visit
9. Annual Eye Exam. Coverage for routine screening eye examinations.	$10.00 Co-pay per office visit. $50.00 benefit maximum per Member per Benefit Period
10. Immunizations.	100% of Eligible charges per visit

BENEFITS (Outpatient)	**Plan Coinsurance or Member Co-pay**
11. Physical Exam, Annual. Coverage for physician fees, laboratory and diagnostic studies. Mammograms are provided in accordance with 4GCA, 4301 (e).	$10.00 Co-pay per office visit. $200.00 benefit limitation per Member per Benefit Period
12. Well-Child-Care. Coverage for physician fees, laboratory and diagnostic studies included in up to five (5) well-child visits per Benefit Period for children under two (2) years of age.	$10.00 Co-pay per office visit
13. Health Education. Coverage for classes provided by the PacifiCare Health Center only.	80% of Eligible Charges
14. Prescription Drugs. Coverage for the original prescription and refill prescription. PacifiCare will pay for only normal and reasonable quantities of a prescription drug, and such quantity shall not in any event exceed an amount, which under normal use will last for more than 30 days. Prescription drugs are generally limited to those within the PacifiCare Formulary. Non-Formulary prescriptions are covered when Medically Necessary and prior authorized by PacifiCare	$10 Co-pay for Generic drugs and $20 Co-pay for Brand drugs, per Prescription Drug Unit Mail-order program: No Co-pay for Generic and Brand Formulary for 90-day supply. $20 Co-pay for non-Formulary per Prescription Drug Unit.
15. Injectable prescription drugs. Coverage for injectable drugs administered at home or in the physician's office.	80% of Eligible Charges; waived if administered through PacifiCare Home Health
16. Birth Control Pills.	Subject to the Prescription Drugs benefit
17. Contraceptive Devices limited to intrauterine devices (IUDs) and diaphragms.	80% of Eligible Charges

Benefits (Outpatient)	**Plan Coinsurance or Member Co-Pay**
18. Physical Therapy. Includes neuromuscular rehabilitation, provided by a covered physical therapist acting within the scope of his or her license subject to the condition that all visits in excess of 20 visits shall be paid at 50% of the Eligible Charges. For physical therapy, only services provided by a registered physical therapist (RPT), or services provided by a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) are recognized for coverage. Physical therapy will be considered necessary when provided to restore a bodily function that once existed and has been lost or damaged due to disease or accidental injury. Such therapy is covered only to the extent that it restores function to the status pre-existing disease or accidental injury. Therapy must result in significant and demonstrable improvement in the Member's ability to function independently. Cognitive function, although dependent on the function of the brain, is not considered a bodily function for purposes of this benefit.	$25.00 Co-pay per visit for 20 visits per Member per Benefit Period. PacifiCare will pay 50% of Eligible Charges thereafter

	BENEFITS (Outpatient)	**Plan Coinsurance or Member Co-pay**
	19. Elective Surgery. (Prior authorization required. The surgery must be Medically Necessary.) PacifiCare will not pay for charges incurred for use of the hospital's outpatient facilities, supplies and equipment in connection with elective minor surgical services or medical services that could be received in a Physician's office or at a plan-contracted surgi-center.	80% of Eligible Charges when prior authorized by PacifiCare
C.	Out-Of-Area Emergency and Referral Services.	80% of Eligible Charges of 1st $5,000, 100% of Eligible Charges of balance up to $100,000 per Benefit Period.
D.	Allergy Testing & Treatment. Charges in connection with allergy testing and treatment. Coverage is limited to allergy serum, allergy injections, testing and treatment.	$25.00 Co-pay per office visit. $500 benefit limitation per Member per Benefit Period
E.	Ambulance Service (Medically Necessary and ground transportation only)	80% of Eligible Charges
F.	Cardiac Surgery.	80% of Eligible Charges up to $50,000 benefit limitation per Member per Benefit Period

	BENEFITS	**Plan Coinsurance or Member Co-pay**
G.	Congenital Abnormality and Complications of the Neonatal Period.	80% of Eligible Charges
H.	Accidental Injury to the Mouth. Palliative (emergency) care provided by a dentist or physician is covered to alleviate pain and other acute symptoms resulting from the injury. Such may include debridement of wounds, suturing, extraction of broken teeth, splinting of loose teeth, wiring of jaws, smoothing jagged edges of broken teeth. Specifically excluded are fillings, crowns, bridges, dentures, bonding and similar permanent restorations.	80% of Eligible Charges.
I.	Home Health Care. Home health care ordered by a Participating Provider rendered by a licensed practitioner or a home health aide. Services include IV therapy and medications. Services ordered by a physician to homebound Members: • Nursing • Physical therapy, respiratory therapy • Medical supplies included in the home health plan of care Note: IV therapy and medications are covered under the prescription drug benefit.	100% of Eligible Charges when provided or authorized by PacifiCare Home Health
J.	Interrupted Pregnancy.	Covered 80% of Eligible Charges when Medically Necessary and in accordance with the law
K.	Plan Maximum Coverage.	$1,000,000 per Member per lifetime

	BENEFITS	**Plan Coinsurance or Member Co-pay**
L.	Durable Medical Equipment. As prescribed by a doctor 1. Wheelchair 2. Hospital bed/commode 3. Oxygen & accessories a. Oxygen concentrator b. Oxygen masks, c. Nasal canula tubing d. One filled oxygen tank (not to exceed 22 cu. ft.), no refills 4. Suction machine 5. Crutches/Walkers 6. Masks	80% of Eligible Charges for the rental or purchase (at PacifiCare's option) of the durable medical equipment when Medically Necessary and authorized by PacifiCare using current criteria set up by Medicare
M.	Nuclear Medicine -prior authorization required	80% of Eligible Charges per visit. $25,000 benefit limitation per Member per Benefit Period

BENEFITS		Plan Coinsurance or Member Co-pay
N.	Radiation Therapy. Limitation applies to therapy provided externally or by internally implanted devices.	80% of Eligible Charges per visit. $25,000 benefit limitation per Member per Benefit Period
O.	Sterilization Procedure.	
	1. Tubal Ligation – outpatient services only unless performed in conjunction with delivery	$25.00 Co-pay
	2. Vasectomy – outpatient services only	$25.00 Co-pay
P.	Eligible off-island Dependent Students -when eligibility requirements are met	Covered Out-of-Area Emergency and Referral Services as stated in section C above
Q.	If an appropriate service is available on Guam, PacifiCare must provide that service on Guam if the service meets industry standards of care acceptable to PacifiCare. PacifiCare's Medical Director will determine the appropriateness of an available service and/or medical facility based on accepted industry standards.	80% of Eligible Charges

	BENEFITS	**Plan Coinsurance or Member Co-pay**
R.	Chronic orthopedic conditions including internal prosthetic devices and external prosthetic devices. Except as specifically excluded under this Agreement, services, supplies and devices related to the treatment of chronic orthopedic conditions are covered. This includes: i. internal and external prosthetic devices including artificial joints, limbs and spinal segments ii. orthotic devices, which are defined as appliances, or apparatus that support or align movable parts of the body, correct deformities or improve the functioning of movable parts of the body not available for purchase as an over-the-counter product. iii. treatment of joint conditions including arthritis iv. treatment of bone conditions including osteoarthritis, osteoporosis, osteosclerosis, spina bifida, bone cell tumors and fractures v. treatment of ligament and cartilage conditions	80% of Eligible Charges up to $50,000 benefit limitation per Member per Benefit Period.
S.	Blood and blood products/derivatives and their administration.	80% of Eligible Charges up to $50,000 benefit limitation per Member per Benefit Period for blood and blood products. Costs incurred for their administration shall not accumulate toward this maximum.

	BENEFITS	Plan Coinsurance or Member Co-pay
T.	Hearing aids. Testing for hearing aids is not covered.	$500 benefit limitation per Member per Benefit Period
U.	Chiropractic Care.	20 visit maximum per Member per Benefit Period. Plan pays $25 maximum per visit
V.	Hospice Care. Member must be expected to die within 6 months and shall not be entitled to any care for the terminal illness except for palliative care. Care must be provided on Guam through a bonafide hospice program.	Maximum of 180 days and one hospice confinement per Member per lifetime. Plan pays $50 maximum per day
W.	Chemical Dependency. Coverage is for all treatment services recommended by a Participating Provider and contained in a treatment plan. The treatment plan may include services, drugs and supplies described elsewhere in this Schedule of Benefits. PacifiCare will cover the services only when PacifiCare determines that the care is Medically Necessary to treat the Member's condition, and only if the Member receives the care as part of a treatment and discharge plan developed by a Participating Provider.	Inpatient services are covered 80% after a $250 Co-pay per admission. Outpatient services are covered with a $25.00 Co-pay per office visit.
	Diagnosis and treatment of alcoholism and drug abuse. Outpatient services include: • Detoxification (the withdrawal process from physically-addictive drugs and/or alcohol when withdrawal is likely to cause medical or life-threatening complications) • Treatment and counseling (including individual and group therapy visits) Note: The Participating Provider will develop a treatment plan to assist the Member in improving or maintaining his or her condition and functional level, or to prevent relapse. • Inpatient substance abuse care • Day treatment programs for substance abuse Note: All inpatient admissions, hospital alternative services, and day treatment programs require approval from PacifiCare. Alternative care settings have a 30- day benefit maximum per Member per Benefit Period.	A maximum of $8,000 per Member per year and $16,000 per Member per life time shall apply to chemical dependency treatments

BENEFITS

		Plan Coinsurance or Member Co-Pay
X.	Breast Reconstruction. All stages of the breast reconstruction surgery following a mastectomy including reconstruction of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of all states of mastectomy, including lymphedemas, are covered. Such reconstruction procedures are not limited to reconstructive procedures necessitated by a mastectomy performed while covered under this plan.	80% of Eligible Charges
Y.	Acupuncture	10 visit maximum per Member per Benefit Period. Plan pays maximum of $50 per visit
Z.	Podiatry Services Foot care only when you are under active treatment for: • Metabolic disease such as diabetes, or • Peripheral vascular disease	$25.00 Co-pay per office visit
AA.	Hyperbaric Oxygen (HBO) Treatment -prior authorization required	80% of Eligible Charges
AB.	In Service Area Out-of-Pocket Maximum: The maximum total out-of-pocket costs, including all Deductibles,Co-payments and Coinsurance that a Member can be held liable for during a Benefit Period for expenses incurred within the Service Area before PacifiCare begins paying 100% of covered benefits. Following are Member expenses which will not accumulate towards the In-Service Area Out-of-Pocket Maximum: (a) expenses in excess of Plan maximums, (b) expenses for non-covered services, (c) expenses incurred Out-of-Service Area, and (d) expenses incurred through non-Participating Providers.	Individual – $2,000 Family - $6,000

BENEFITS		Plan Coinsurance or Member Co-Pay
AC.	Out-of-Service Area Out-of-Pocket Maximum: The maximum total out-of-pocket costs, including all Co-payments and Coinsurance and Deductible that a Member can be held liable for during a Benefit Period for expenses outside the Service Area before PacifiCare begins paying 100% of covered benefits.	The lesser of $1000 or 20% of the first $5,000.
AD.	Deductible: This deductible must be met before benefits can be administered by the Plan. The deductible can be applied to the Out-of-Pocket Maximums.	$500 Individual $1,500 Family
AE.	Network: Access is limited to the PacifiCare Health Center and the Guam Seven Day Adventist Clinic for services available on Guam for primary and specialty care, unless otherwise specifically approved by PacifiCare.	
AF.	This option B sunsets on September 30, 2003 and is available only during the period October 1, 2002 through September 30, 2003.	

EXCLUSIONS

1. No benefits will be paid for injury or illness, (a) when the Member is entitled to receive disability benefits or compensation (or forfeits his or her right thereto) under Worker's Compensation or Employer's Liability Law for such injury or illness or (b) when services for an injury or illness are rendered to the Member by any federal, state, territorial, municipal or other governmental instrumentality or agency without charge, or (c) when such services would have been rendered without charge but for the fact that the person is an Member under the Plan

2. No benefits will be paid if any material statement made in an application for coverage, in enrollment of any dependent or in any claim for benefits is false. Upon identifying any such false statement, Company shall notify the Member that his or her benefits have been suspended and that his or her coverage shall be terminated retroactive to the date of suspension unless the Member files a claim under the grievance procedure provided for in the agreement. If a grievance is filed, the resolution of the matter shall be in accordance with the outcome of the grievance proceedings. If no grievance is filed, and Company paid benefits, prior to learning of any such false statement, the subscriber must reimburse the Company for such payment

3. No benefits will be paid for confinement in a hospital or in a skilled nursing facility if such confinement is primarily for custodial or domiciliary care (Custodial or domiciliary care includes that care which consists of training in personal hygiene, routine nursing services and other forms of self-care. Custodial or domiciliary care also includes supervisory services by a physician or nurse for a person who is not under specific medical or surgical treatment to reduce his or her disability and to enable that person to live outside an institution providing such care)

4. No benefits will be paid for services and supplies and drugs not specifically described as covered in the Agreement

5. No benefits will be paid for services and supplies and drugs provided to an Member for and injury or illness resulting from an attempted suicide by that Member unless resulting from a medical condition (including physical or mental conditions) or from domestic violence

6. No benefits will be paid for services and supplies and drugs provided to an Member for injuries incurred while that Member was committing a criminal act

7. Unless otherwise specifically provided in the agreement, no benefit will be paid for or in connection with airfare and the Company will not pay for the transportation from Guam to any off-island facility, nor for any other non-medical expenses such as taxes, taxis, hotel rooms, etc. In no event will the Company pay for air ambulance or for the transportation of the remains of any deceased person

EXCLUSIONS

8. No benefit will be paid for living expenses for insureds who require, or who of their own accord seek, treatment in locations removed from their home

9. No benefit will be paid for services and supplies and drugs provided to a dependent of a non-spouse dependent. Dependents of non-spouse dependents are not eligible for coverage. For example, when a dependent, other than a spouse of the subscriber, has a child, that child is a dependent of a non-spouse dependent and is not eligible to become covered under the Plan, unless such child otherwise becomes eligible for enrollment

10. No benefit will be paid for services furnished by immediate relatives or members of the Member's household unless service rendered by such persons are rendered as employees of a hospital, physician, or other provider

11. No benefit will be paid for services and supplies and drugs provided for occupational and/or speech therapy regardless of the condition for which such services and supplies and drugs are provided

12. No benefit will be paid for charges made by a provider for services provided through telephone conferences or interviews during which the Member is not seen for treatment

13. No benefit will be paid for:

    a) drugs or substances not approved by the Food and Drug Administration (FDA); or

    b) drugs or substances not approved by the FDA for treatment of the illness or injury being treated unless empirical clinical studies have proven the benefits of such drug or substance in treating the illness or injury; or

    c) drugs or substances labeled "Caution: limited by federal law to investigational use"

14. No benefit will be paid in connection with or for experimental procedures not approved by payment by Medicare

15. No benefit will be paid for any item or substances that is available without a physician's prescription even if prescribed by a physician, except as otherwise provided herein and except for medicines and supplies Medically Necessary for inpatient care

EXCLUSIONS

16. No benefits will be paid for services and supplies and drugs provided to perform transsexual surgery or to evaluate the need for such surgery. Evaluations and subsequent medications and services necessary to maintain transsexual status are also excluded from coverage, as are complications or medical sequelae of such surgery or treatment

17. No benefit will be paid for injuries incurred while operating a motorized vehicle while under the influence of intoxicating alcoholic beverage, controlled drugs, or substances. If a blood alcohol level or the DRAEGER ALCO TEST is available and shows levels that are equal to or exceed 0.08 grams percent (gms%) or that exceed the amount allowed by law as constituting legal intoxication, no benefits will be paid

18. No benefit will be paid for services and supplies and drugs provided for visual training, including the provision of special prism lenses

19. No benefit will be paid for medical service or supply which is available to the Member on Guam and which is paid by or reimbursable through a governmental agency or institution. However, notwithstanding the aforesaid, in no event will the company consider the availability of benefits under Medicaid or the Medically Indigent Program when paying benefits under this Agreement

20. No benefits will be paid for audiograms, regardless of the reason for such tests

21. No benefit will be paid for services and supplies and drugs for the treatment or diagnosis of temporomandibular joint (TMJ) disorders. This includes, but is not limited to:
    a) services of a Dentist;
    b) bite plates;
    c) braces to straighten the teeth;
    d) orthognathic surgery to correct a bite defect;
    e) surgical procedures in direct treatment of TMJ, including surgery on the joint itself or on the Hyoid bone;
    f) arthrogram or other X-ray of the TMJ, and also including magnetic reasonance imaging
    g) biofeedback or the insertion of TENS units or related devices